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EXECUTIVE ORDER BJ 15-19

Flags at Half Staff

WHEREAS, on Sunday, August 23, 2015, Senior Trooper Steven Vincent of the Louisiana State Police was shot in the line of duty while attempting to provide assistance to an impaired driver;

WHEREAS, several passing motorists risked their lives to provide immediate assistance to Trooper Vincent and successfully apprehended the suspect;

WHEREAS, on Monday, August 24, 2015, Trooper Vincent succumbed to his injuries and passed away this morning. Trooper Vincent was an honorable man who proudly served on the Louisiana State Police for thirteen years;

WHEREAS, Trooper Vincent is survived by his wife, Katherine, and his son, Ethan. The thoughts and prayers of all Louisianians are with Trooper Vincent's family and the entire Louisiana State Police community;

WHEREAS, our law enforcement men and women bravely risk their lives every day to protect our communities and our citizens, and we are all extremely grateful for their dedicated service.

NOW THEREFORE, I, BOBBY JINDAL, 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: As an expression of respect for Trooper Steven Vincent, the flags of the United States and the State of Louisiana shall be flown at half staff over the State Capitol and all public buildings and institutions of the State of Louisiana until sunset on Friday, August 28, 2015.

SECTION 2: This Order is effective upon signature and shall remain in effect until sunset, Friday, August 28, 2015, unless amended, modified, terminated, or rescinded prior to that date.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 24th day of August, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1509#008

EXECUTIVE ORDER BJ 15-20

Transition of the Early Childhood Advisory Council to the Advisory Council on Early Childhood Care and Education

WHEREAS, a *state advisory council on early childhood education and care* is an important mechanism necessary to build, maintain, and strengthen a

comprehensive, outcomes-based, integrated early childhood system that ensures all children enter Kindergarten prepared for success;

WHEREAS, 42 U.S.C. 9837b(b)(1)(A) requires the Governor to designate or establish a council to serve as the *state advisory council on early childhood education and care* for children from birth to school entry;

WHEREAS, Executive Order No. BJ 2013-13 directed the Children's Cabinet to create an *early childhood advisory council* (ECAC) to serve as Louisiana's state advisory council, with all members appointed by the Governor and serving without compensation;

WHEREAS, La. R.S. 17:407.51, effective October 1, 2014, requires the State Board of Elementary and Secondary Education to establish an Advisory Council on Early Childhood Care and Education, and at its monthly meeting on October 15, 2014, the Board approved appointments to the Council made by the State Superintendent of Education;

WHEREAS, it is in the best interest of the citizens of the state of Louisiana to transition this centralized and coordinated effort from the ECAC to the Advisory Council on Early Childhood Care and Education created under the State Board of Elementary and Secondary Education per La. R.S. 17:407.51.

NOW THEREFORE, I, Bobby Jindal, 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: The Advisory Council on Early Childhood Care and Education (hereafter "Council"), established pursuant to La. R.S. 17:407.51, is hereby designated to serve as the *state advisory council on early childhood education and care* for children from birth to school entry per 42 U.S.C. 9837b(b)(1)(A).

SECTION 2: In accordance with La. R.S. 17:407.51, the Council shall consist of 17 voting members and 13 nonvoting ex officio members. The members of the Council shall not receive compensation or a per diem for their services or attendance at council meetings.

SECTION 3: The chair of this Council shall be elected by the voting members of the Council and shall coordinate activities of the Council. The Council shall be responsible for the duties set forth in La. R.S. 17:407.51

SECTION 4: Executive Order No. BJ 2013-13 is hereby terminated, effective August 26, 2015.

SECTION 5: All departments, commissions, boards, offices, entities, agencies, and officers of the State of Louisiana, or any other political subdivision thereof, are authorized and directed to cooperate with the Council and BESE in implementing and maintaining the provisions of this Order.

SECTION 6: This Order is effective upon signature and shall continue 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

Louisiana, at the Capitol, in the city of Baton Rouge, on this 27th day of August, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1509#010

EXECUTIVE ORDER BJ 15-21

Flags at Half Staff Extended

WHEREAS, on Sunday, August 23, 2015, Senior Trooper Steven Vincent of the Louisiana State Police was shot in the line of duty while attempting to provide assistance to an impaired driver;

WHEREAS, several passing motorists risked their lives to provide immediate assistance to Trooper Vincent and successfully apprehended the suspect;

WHEREAS, on Monday, August 24, 2015, Trooper Vincent succumbed to his injuries and passed away. Trooper Vincent was an honorable man who proudly served on the Louisiana State Police for thirteen years;

WHEREAS, Trooper Vincent is survived by his wife, Katherine, and his son, Ethan. The thoughts and prayers of all Louisianians are with Trooper Vincent's family and the entire Louisiana State Police community;

WHEREAS, our law enforcement men and women bravely risk their lives every day to protect our communities and our citizens, and we are all extremely grateful for their dedicated service;

WHEREAS, Executive Order No. BJ 2015-19, issued on August 24, 2015, ordered the flags of the State of Louisiana to be flown at half staff, as an expression of respect for Trooper Steven Vincent, through sunset Friday, August 28, 2015;

WHEREAS, Trooper Vincent will be laid to rest on Saturday, August 29, 2015 in Lacassine, Louisiana following a funeral at Our Lady Queen of Heaven Catholic Church in Lake Charles.

NOW THEREFORE, I, BOBBY JINDAL, 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: As an expression of respect for Trooper Steven Vincent, the flags of the United States and the State of Louisiana shall continue to be flown at half staff over the State Capitol and all public buildings and institutions of the State of Louisiana until sunset on Saturday, August 29, 2015.

SECTION 2: This Order is effective upon signature and shall remain in effect until sunset, Saturday, August 29, 2015, unless amended, modified, terminated, or rescinded prior to that date.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 28th day of August, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1509#012

EXECUTIVE ORDER BJ 15-22

Flags at Half Staff

WHEREAS, on Wednesday, September 26, 2015, Officer Henry Nelson of the Sunset Police Department was shot in the line of duty while responding to a report of a domestic dispute;

WHEREAS, Officer Nelson was a lifelong resident of Sunset and proudly served on the Sunset Police Department since 2002; he is survived by his daughter, Alyssa;

WHEREAS, thoughts and prayers of all Louisianians are with Officer Nelson's family and the entire Sunset community;

WHEREAS, our law enforcement men and women bravely risk their lives every day to protect our communities and our citizens, and we are all extremely grateful for their dedicated service.

WHEREAS, Officer Nelson will be laid to rest on Saturday, September 5, 2015, following a funeral at Zion Traveler's Church in Sunset, Louisiana.

NOW THEREFORE, I, BOBBY JINDAL, 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: As an expression of respect for Officer Henry Nelson, the flags of the United States and the State of Louisiana shall be flown at half staff over the State Capitol and all public buildings and institutions of the State of Louisiana until sunset on Saturday, September 5, 2015.

SECTION 2: This Order is effective upon signature and shall remain in effect until sunset, Saturday, September 5, 2015, unless amended, modified, terminated, or rescinded prior to that date.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 4th day of September, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1509#047

EXECUTIVE ORDER BJ 15-23

In Memoriam

WHEREAS, every year, on September 11th, the people of Louisiana recognize and honor all those who lost their lives on September 11, 2001, as well as the heroic men and women who sacrificed their lives through civilian and military service in connection with related ongoing overseas combat operations;

WHEREAS, since September 11, 2001, the people of Louisiana have lost many brave men and women in these combat operations and more are currently risking their lives daily in defense of our freedom;

WHEREAS, September 11, 2015, marks the fourteen year anniversary of the tragic events that occurred on September 11, 2001, and provides a special opportunity for remembering their patriotic commitment to the democratic principles of freedom and equality;

WHEREAS, these service members represent all branches of the armed forces, the Marines, Army, Air Force, Navy, Coast Guard, National Guard and Reserves;

WHEREAS, these courageous and ambitious Louisianians loved their country and the military and devoted their lives to serving their state and country;

WHEREAS, all tragically lost their lives giving their last full measure of devotion in defense of our beloved country and the freedoms that we as Americans hold dear;

WHEREAS, the memory of these dedicated men and women will live on in the hearts of their family, friends, and fellow service members forever.

NOW THEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and the laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: As an expression of respect for Louisiana's fallen civilian and service members who lost their lives on September 11, 2001, and the days since to defend this country, as well as those who continue to proudly serve, the flags of the United States and the State of Louisiana shall be flown at half staff over the State Capitol and all public buildings and institutions of the State of Louisiana from sunrise September 11, 2015, until sunset September 11, 2015.

SECTION 2: This Order is effective upon signature and shall remain in effect until amended, modified, terminated or rescinded.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 11th day of September, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1509#095

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences

Horticulture and Quarantine Programs Emerald Ash Borer Quarantine (LAC 7:XV.167)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), and the authority of the state entomologist pursuant to R.S. 3:1652, and in order to avoid a lapse in coverage until a permanent Rule is in effect, notice is hereby given that the Department of Agriculture and Forestry is adopting these emergency regulations establishing a quarantine for the following pest: emerald ash borer (“EAB”), *Agrilus planipennis* fairmaire. The state entomologist has determined that EAB has been found in this state and may be prevented, controlled, or eradicated by quarantine.

EAB poses an imminent peril to the health and welfare of Louisiana forests, commercial and private forestry/wood product industries, and nursery growers due to its ability to infest ash trees. In 2013, the wholesale value of woody ornamental sales for nursery growers in the state was \$62.6 million, a portion of which is comprised of sales of ash trees (Louisiana State University AgCenter 2013 Louisiana Summary, Agriculture and Natural Resources). Louisiana’s forests and forestry/wood products industries generated an output industry production value of \$10.86 billion in 2012, a portion of which is comprised of ash trees and ash tree products (Louisiana State University AgCenter publication 3367-G, 2015). Sales of ash firewood by retail and wholesale suppliers to private individuals also are important to the state’s economy.

Natural spread of EAB is limited to relatively short distances. However, without restriction, EAB can spread through human-assisted means over long distances via infested ash nursery stock, ash logs/timber and cut firewood. Once an ash tree is infested, it experiences twig dieback and tree decline. Tree death occurs within a few years. Failure to prevent, control, or eradicate this pest threatens to damage Louisiana’s commercial ash tree nursery industry, and over time this pest poses a threat to destroy the majority of ash in our state, both commercial and residential. The loss of the state’s commercial nursery-grown ash trees, forestry/wood ash products and even residential ash trees would be devastating to the state’s economy and to its private citizens. The quarantine established by this emergency regulation is necessary to prevent the spread of EAB to all areas in Louisiana where ash may exist, outside of the current areas where this pest has been found.

For these reasons, the presence of EAB in Louisiana presents an imminent peril to the health, safety and welfare of Louisiana’s citizens and forests, the state’s commercial and private forestry/wood product industries, and nursery

growers. As a result of this imminent peril, the Department of Agriculture and Forestry, Office of Forestry and Office of Agricultural and Environmental Sciences, hereby exercises its full and plenary power pursuant to R.S. 3:1652 to deal with crop and fruit pests and contagious and infectious crop and fruit diseases by imposing the quarantines set out in these emergency regulations.

This Rule shall have the force and effect of law effective September 20, 2015 and will remain in effect 120 days, unless renewed by the commissioner of agriculture and forestry or until permanent rules are promulgated in accordance with law.

Title 7

AGRICULTURE AND ANIMALS

Part XV. Plant Protection and Quarantine

Chapter 1. Crop Pests and Diseases

Subchapter F. Emerald Ash Borer Quarantine

§167. Emerald Ash Borer Quarantine

A. The department issues the following quarantine because the state entomologist has determined that the insect emerald ash borer (“EAB”), *Agrilus planipennis*, has been found in this state and may be prevented, controlled, or eradicated by quarantine.

B. Quarantined areas in this state include:

1. the entire parishes of Bossier, Claiborne and Webster;
2. a declaration of quarantine for EAB covering any other specific parishes or areas of this state shall be published in the official journal of the state and in the *Louisiana Register*.

C. No regulated articles as defined in this Section shall be moved out of any area of this state that is listed in this Section as a quarantined area for EAB, except as provided in this Section.

D. The following articles are hosts of EAB and are deemed to be regulated articles for purposes of this Subsection:

1. the emerald ash borer in all of its life stages; firewood of all hardwood (non-coniferous) species; nursery stock, green lumber, and other material living, dead, cut, or fallen, including logs, stumps, roots, branches, and composted and uncomposted chips of the genus *Fraxinus*;

2. any other article, product, or means of conveyance not listed in this Section may be designated as a regulated article if an inspector determines that it presents a risk of spreading emerald ash borer and notifies the person in possession of the article, product, or means of conveyance that it is subject to the restrictions of the regulations.

E. Regulated articles may be moved from quarantined areas to non-quarantined areas within or outside of Louisiana only if moved under the following conditions.

1. The regulated articles being moved are accompanied by a certificate or limited permit issued by LDAF and attached in accordance with the EAB federal requirements.

DECLARATION OF EMERGENCY

**Department of Children and Family Services
Division of Programs
Child Welfare**

Guardianship Subsidy Program
(LAC 67:V.4101 and 4103)

2. The regulated articles being moved are not accompanied by a certificate or limited permit but are being moved by the United States Department of Agriculture for experimental or scientific purposes.

3. The regulated articles being moved are not accompanied by a certificate or limited permit but originated outside of any EAB quarantined area and are moved interstate through the quarantined area under the following conditions:

- a. the points of origin and destination are indicated on a waybill accompanying the regulated article; and
- b. the regulated article, if moved through the quarantined area, is moved in an enclosed vehicle or is completely covered to prevent access by the EAB; and
- c. the regulated article is moved directly through the quarantined area without stopping (except for refueling or for traffic conditions, such as traffic lights or stop signs), or has been stored, packed, or handled at locations approved by an inspector as not posing a risk of infestation by emerald ash borer; and
- d. the article has not been combined or commingled with other articles so as to lose its individual identity.

F. Persons or businesses engaged in growing, handling, or moving regulated articles intrastate may enter into a compliance agreement with LDAF if such persons or businesses review with an LDAF inspector each provision of the compliance agreement. Any person or business who enters into a compliance agreement with LDAF must agree to comply with the provisions of this Subpart and any conditions imposed under this Subpart.

1. Any compliance agreement may be canceled orally or in writing by an inspector whenever the inspector determines that the person who has entered into the compliance agreement has not complied with this Subpart or any conditions imposed under this Subpart. If the cancellation is oral, the cancellation will become effective immediately, and the cancellation and the reasons for the cancellation will be confirmed in writing as soon as circumstances permit. Any person whose compliance agreement has been canceled may appeal the decision in writing to LDAF within 10 days after receiving the written cancellation notice. The appeal must state all of the facts and reasons that the person wants LDAF to consider in deciding the appeal. A hearing may be held to resolve a conflict as to any material fact. Rules of practice for the hearing will be adopted by LDAF. As soon as practicable, LDAF will grant or deny the appeal, in writing, stating the reasons for the decision.

G. Any person violating this quarantine shall be subject to imposition of the remedies and penalties set forth in R.S. 3:1653.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1652, 3:1653.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, LR 41:

Mike Strain, DVM
Commissioner

1509#060

The Department of Children and Family Services, Child Welfare Section, has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B), to amend LAC 67:V, Subpart 5 Foster Care, Chapter 41 Guardianship Subsidy Program, Sections 4101 and 4103. This declaration is necessary to extend the original Emergency Rule since it is effective for a maximum of 120 days and will expire before the Final Rule takes effect. This Emergency Rule extension is effective on October 7, 2015 and will remain in effect until the Final Rule becomes effective.

Pursuant to United States Children’s Bureau requirements for authorization of Louisiana’s Title IV-E State Plan, adjustments to the foster care and guardianship subsidy programs are necessary to update required terminology related to the programs, types of available payments, and eligibility criteria. The proposed rule will amend the option of Subsidized Guardianship and establish Successor Guardianship as a permanency option, therefore promoting the establishment of permanent families for children within relative foster care placements where adoption is not an alternative.

The department considers emergency action necessary in order to fulfill Title IV-E State Plan requirements and to avoid sanctions and penalties from the United States Children’s Bureau.

Title 67

SOCIAL SERVICES

Part V. Child Welfare

Subpart 5. Foster Care

Chapter 41. Guardianship Subsidy Program

§4101. Subsidizing Guardianship Arrangements for Children in Foster Care

A. Overview of Program Purpose

1. The Subsidized Guardianship Program enables the Department of Children and Family Services (DCFS) to make payments to certified relative and fictive kin caregivers on behalf of a child who otherwise might not be able to achieve permanency outside of department custody because of special needs or other circumstances. Subsidy payments shall be limited to a child(ren) for whom guardianship is indicated due to other more permanent options such as reunification with the parents, immediate unsubsidized custody to a relative or other caregiver, or adoption being determined unfeasible for the child. The guardianship subsidy applies only to a child(ren) for whom the (DCFS) holds legal custody, only to potential caregivers with whom the child had an established familial or emotional relationship prior to entering (DCFS) custody, and when the kinship placement provider becomes a certified foster caregiver according to the certification standards of the State, and, the child(ren) remains in the certified kinship

placement for at least six consecutive months immediately prior to entering the guardianship subsidy arrangement. The guardianship subsidy also applies to successor guardian(s) who meet the following criteria:

- a. The successor guardian is named in the guardianship subsidy agreement with DCFS;
- b. The successor guardian and all adult household members have satisfactorily completed fingerprint based criminal and child abuse/neglect background clearances; and
- c. Guardianship is transferred by a court to the successor guardian in accordance with Louisiana Children's Code Articles 718 through 724.1.

2. The prospective guardianship family must meet basic foster care certification eligibility requirements or the successor guardianship criteria in all respects except for the ability to assume complete financial responsibility for the child's care.

B. Types of Subsidy Payments. The child may be subsidized for the following services up to age 18.

1. Maintenance. The maintenance subsidy includes basic living expenses such as board, room, clothing, spending money, and ordinary medical costs. The maintenance subsidy may be ongoing until the child reaches age 18, but must be renewed on a yearly basis. This renewal will be dependent upon the child remaining in the care of the guardian with whom the subsidy agreement was established. The amount of payment shall not exceed 80 percent of the state's regular foster care board rate based on the monthly flat rate payments of the regular foster care board rate for the corresponding age group. Monthly maintenance payments shall not be based on subsidized foster care arrangements such as specialized foster care, alternate family care, or therapeutic foster care. Changes in the maintenance subsidy rate routinely only occur once a year and the adjustment is typically made at the time of the subsidy renewal, or due to a change in the child's age. Adjustments to the maintenance subsidy rate may also occur due to availability of funds, legislative changes or adjustments to the regular foster care board rate.

2. Special Board Rate. Foster parents entering into a guardianship agreement for a foster child for whom a special board rate was received during the foster care episode may request up to a maximum of \$240 which is 80 percent of the special board rate amount of \$300. This is only provided if the care and needs of the child in the guardianship arrangement warrant this same special board rate. The continued need for the special board rate shall be reviewed at the time of the annual review. This review shall consist of a determination of whether the same level of specialized care by the guardian, for which the special board rate was being provided at the time of the subsidy agreement, continues to be necessary to meet the child's needs. Any reduction in the level of care required by the guardian should result in a decrease in the amount of special board rate compensation to the guardian.

3. Special Services

a. The special services subsidy is time limited and in some cases may be a one-time payment. It is the special assistance given to handle an anticipated expense when no other family or community resource is available. If needed, it can be offered in addition to the maintenance and special board rate subsidy. The special services subsidy must be

established as a part of the initial guardianship subsidy agreement, and may not be provided or renegotiated based on any circumstances which develop or issues identified after that point. Special services subsidies include the following types of needs:

i. special medical costs deemed medically necessary for the daily functioning of the child for any condition existing prior to the date of the initial judgment establishing guardianship with the kinship caregiver and not covered by Medicaid or other insurance;

ii. ongoing therapeutic treatment costs to complete current therapy and future treatment costs on a time limited basis up to 18 years of age, as agency resources allow, related to the abuse/neglect received by the child and impacting the child's capacity to function effectively as part of the child's educational, family or social environment. This does not include the cost of residential care or psychiatric hospitalization, nor does it include therapeutic intervention for the sole purpose of providing behavior management assistance to the guardian;

iii. legal and court costs to the potential guardian family up to \$1000 for children who are not Title IV-E eligible and up to \$2000 for children who are Title IV-E eligible for establishing the guardianship arrangement. This service is only available for costs distinct and separate from the routine costs of the child in need of care proceedings to provide for costs to the potential guardian in establishing the guardianship arrangement. This legal and/or court fee will be provided as a non-reoccurring, one-time payment for each guardianship episode.

b. Medicaid Eligibility. The child remains eligible for Medicaid coverage up to 18 years of age when entering a guardianship subsidy arrangement from foster care. This coverage will be eligible utilizing Title IV-E federal benefits if the child was Title IV-E eligible at the time of the subsidy arrangement. For children not eligible for Title IV-E, this coverage will be provided through Title XIX federal benefits or state general funds. For a Louisiana child who is placed out of state in a potential guardianship placement or who moves to another state after the establishment of a guardianship subsidy, if the child is eligible for Title IV-E guardianship subsidy payments, the child is also categorically eligible for Medicaid in the state in which the child resides whether that state participates in the Title IV-E Guardianship Subsidy Assistance Program or not.

c. Chaffee Foster Care Independent Living Skills Training and Education Training Voucher Eligibility. The child is eligible for consideration for participation in the Chaffee Foster Care Independent Living Skills Training and for Education Training Vouchers if the child enters a guardianship arrangement from foster care after reaching 16 years of age, as long as the child meets any other program eligibility requirements.

C. Exploration of Guardianship Resources

1. Before a child is determined by the Department of Children and Family Services (DCFS) as eligible for a guardianship subsidy, it must be determined the child can not be reunited with the parents, and resources for adoptive placement must be explored by the child's worker. If the kinship family with whom the child is placed refuses to adopt the child or is unable to be certified as an adoptive family, the department has to show efforts to achieve the

more permanent case goal of adoption for the child and demonstrate the benefits of maintaining the child in the placement in a guardianship arrangement as opposed to ongoing efforts in pursuing adoption or any other long term permanency arrangement. It is also necessary for the child's worker to discuss plans for a guardianship arrangement with the child and document the outcome of that discussion with the child, including agreement with that plan by any child 14 years of age up to 18 years of age. Lack of agreement by any child 14 years of age up to 18 years of age should be an ongoing topic of counseling regarding the benefits of the arrangement between the worker and the child, until a permanency option is achieved for the child or until the child attains 18 years of age.

2. Whenever an eligible child in the custody of DCFS is legally placed based on the Interstate Compact on the Placement of Children guidelines with a certified kinship caregiver in another state, the family shall be eligible for a guardianship subsidy under the same conditions as Louisiana residents.

D. Eligibility Criteria

1. The DCFS, Guardianship Subsidy Program, will determine the appropriateness of subsidy benefits, the type of subsidy, and, the level of the subsidy. An agreement form between the DCFS and the prospective guardianship parent(s), with clearly delineated terms, including designation of a successor guardian, if desired, must be signed prior to the granting of the final decree for guardianship. This agreement will be reviewed on an annual basis thereafter by the DCFS to insure ongoing eligibility.

2. Subsidy payments shall be limited to a child(ren) for whom guardianship is indicated due to other more permanent options such as reunification with the parents, or adoption being determined unfeasible for the child. The exception would be any child who has been receiving a subsidy payment and enters a successor guardianship. A more permanent option for placement is not required as these children do not re-enter state custody.

3. The guardianship subsidy applies only to a child(ren) for whom the DCFS holds legal custody, only to potential caregivers with whom the child had an established familial or emotional relationship prior to entering DCFS custody, and when the kinship placement provider becomes a certified foster caregiver according to the certification standards of the State, and, the child(ren) remains in the certified kinship placement for at least six consecutive months immediately prior to entering the guardianship subsidy arrangement. The exception would be children entering a successor guardianship. There is no requirement for the child to be in DCFS custody, to be with a caregiver with an established relationship, for certification of the caregiver, nor for a child to be placed with the successor guardian for any length of time prior to entering the guardianship subsidy arrangement.

4. A family is considered eligible for participation in the Guardianship Subsidy Program if they are related to the child or family of the child through blood or marriage or if there exists a fictive kin relationship, which is defined as a relationship with those individuals connected to an individual child or the family of that child through bonds of affection, concern, obligation, and/or responsibility prior to the child's original entry into the custody of the state, and

the individual(s) are considered by the child or family to hold the same level of relationship with the child or family as those individuals related by blood or marriage. The exception would be an individual considered for the successor guardianship named by the guardian in the guardianship subsidy agreement with DCFS.

E. Effects of Deaths of Guardians on Guardianship Subsidy

1. When a child has been placed in an approved guardianship placement with a guardianship subsidy agreement in effect and the guardian dies prior to the child reaching the age of majority, the child's eligibility for a guardianship subsidy shall not be affected if a successor guardian was named in the guardianship subsidy agreement. The child may remain in the care of a duly designated tutor/guardian as established by the guardian family prior to their death, without further involvement of the department. If the "duly designated" tutor/guardian requires financial assistance to maintain the care of the child and the individual was named in the guardianship subsidy agreement as a successor guardian, it is not necessary for the child to return to state custody and those individuals to become certified foster parents.

2. If no successor guardian was named in the guardianship subsidy agreement, any individual otherwise legally designated as a tutor/guardian for the child and requiring financial assistance to sustain the care of the child would have to return the child to state custody and those individuals would have to become certified foster parents. Adoption of the child by the family should be explored as well, since adoption is a more permanent relationship for the child and family. If the family and home are determined to be safe for the care of the child through assessment of the home environment, fingerprint based criminal records clearance, and child abuse/neglect clearances, the child may remain in the care of the family while they are certified.

3. Where a guardianship subsidy agreement is in effect and the guardians both die prior to the child reaching the age of majority, the subsidy agreement will end. The child may remain in the care of a duly designated tutor/guardian as established by the family prior to their death, without further involvement of the department.

4. If the designated tutor/guardian requires financial assistance to maintain the care of the child, it will be necessary for the child to return to state custody and those individuals to become certified as foster parents and provide care to the child six consecutive months after certification and immediately prior to entering into a guardianship subsidy agreement with the department. During the process of becoming certified as foster parents the family may continue to provide care to the child, as long as they are determined to be safe caregivers through a minimum of: (1) department assessment of the home environment; (2) fingerprint based criminal records clearances on all adults in the home; and (3) child abuse/neglect clearances on all adults in the home. Adoption of the child by the family will be explored by the department as well. There can be no financial support of the child by the state while being cared for by the family until such family has been certified, other than incidental expenditures routinely reimbursed to other non-certified caregivers of children in foster care. Each guardianship arrangement is considered a new episode.

Therefore, the agency may provide legal and court costs to support the establishment of this new legal guardianship arrangement between the potential guardian and the child up to \$1000 for children who are not Title IV-E eligible and up to \$2000 for children who are Title IV-E eligible.

AUTHORITY NOTE: Promulgated in accordance with P.L. 110-351 and P.L. 113-183.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 36:552 (March 2010), amended by the Department of Children and Family Services, Division of Programs, Child Welfare, LR 41:

§4103. Nonrecurring Expenses in Guardianship Arrangements

A. The Department of Children and Family Services (DCFS) sets forth criteria for reimbursement of nonrecurring expenses associated with establishing guardianship arrangements for children in foster care.

1. The amount of the payment made for nonrecurring expenses associated with establishing guardianship arrangements for children in foster care shall be determined through agreement between the guardian(s) and the (DCFS). The agreement must indicate the nature and amount of the nonrecurring expenses to be paid.

2. The agreement for nonrecurring expenses must be signed prior to the final decree granting guardianship.

3. There must be no income eligibility requirement for guardian(s) in determining whether payments for nonrecurring expenses associated with establishing guardianship arrangements for children in foster care shall be made. However, potential guardians cannot be reimbursed for out-of-pocket expenses for which they have otherwise been reimbursed.

4. The maximum rate of reimbursement for nonrecurring expenses has been set at \$1000 for children who are not Title IV-E eligible and up to \$2000 for children who are Title IV-E eligible per guardianship arrangement.

5. In cases where siblings are placed and guardianship arrangements established, whether separately or as a unit, each child is treated as an individual with separate reimbursement for nonrecurring expenses up to the maximum amount allowable for each child.

6. In cases where a child has been returned to the custody of the state and a guardianship arrangement dissolved, the child is allowed separate and complete reimbursement for nonrecurring expenses up to the maximum amount allowable for establishing another guardianship arrangement.

7. Reimbursement is limited to costs incurred by or on behalf of guardian(s) not otherwise reimbursed from other sources. Payments for nonrecurring expenses shall be made directly by the (DCFS).

8. When the guardianship arrangement for the child involves interstate placement, Louisiana will only be responsible for paying the nonrecurring expenses for the arrangement for the child when Louisiana is the child's legal custodian and enters into the guardianship subsidy agreement with the caregiver.

9. The term nonrecurring expenses in relation to guardianship arrangements means reasonable and necessary legal fees, court costs, attorney fees and other expenses which are directly related to the legal establishment of the guardianship arrangement for a child in foster care, which are not incurred in violation of state or federal law, and

which have not been reimbursed from other sources or other funds. Other expenses which are directly related to the legal establishment of the guardianship arrangement for a child in foster care means the costs of the arrangement incurred by or on behalf of the guardians and for which guardians carry the ultimate liability for payment. Such costs may include but are not limited to travel costs for the child and/or guardians to be present for the legal proceedings to establish the guardianship arrangement.

AUTHORITY NOTE: Promulgated in accordance with P.L. 110-351 and P.L. 113-183.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 36:554 (March 2010), amended by the Department of Children and Family Services, Division of Programs, Child Welfare, LR 41:

Suzy Sonnier
Secretary

1509#015

DECLARATION OF EMERGENCY

Department of Children and Family Services Division of Programs Licensing Section

Reasonable and Prudent Parent Standards
(LAC 67:V.6703, 6708, 7105,
7111, 7305, 7311, 7313, and 7315)

The Department of Children and Family Services (DCFS) has exercised the emergency provisions of the Administrative Procedure Act, R.S. 49:953 (B) to amend LAC 67:V, Subpart 8, Chapter 67 Maternity Home, Sections 6703 and 6708; Chapter 71 Child Residential Care Class A, Sections 7105 and 7111; and Chapter 73 Child Placing Agencies, Sections 7305, 7311, 7313, and 7315. This Emergency Rule shall be effective September 1, 2015 and shall remain in effect for a period of 120 days.

In accordance with Public Law 113-183 and Act 124 of the 2015 Regular Legislative Session, the use of the "reasonable and prudent parent standard" is permitted, under certain circumstances, by a foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. Reasonable and prudent parent standard is the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities. Standards mandated in this rule shall be met at all times. Any violation of the provisions of this Rule may result in sanctions against the facility, including but not limited to; removal of any and all children placed in or by the facility; ineligibility to receive state or federal funding for the care and/or supervision of such children or for services related thereto, whether directly or indirectly; revocation of the facility's license; and legal action to immediately remove any child in the facility's care or under the facility's supervision.

The department considers emergency action necessary to comply with Public Law 113-183 and Act 124 of the 2015 Regular Legislative Session.

Title 67
SOCIAL SERVICES
Part V. Child Welfare
Subpart 8. Residential Licensing
Chapter 67. Maternity Home

§6703. Definition

- A. ...
- B. Additional Definitions
 - 1. Definitions, as used in this Chapter:

* * *

Age or Developmentally Appropriate Activities or Items—activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

* * *

Reasonable and Prudent Parent Standard—standard that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities. The standard is characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child.

Reasonable and Prudent Parent Training—training that includes knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities. This includes knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child and knowledge and skills relating to applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities. Activities include sports, field trips, and overnight activities lasting one or more days. Also included is knowledge and skills in decisions involving the signing of permission slips and arranging of transportation for the child to and from extracurricular, enrichment, and social activities.

* * *

- B.2 - B.2.d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and R.S. 46:1401et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), repromulgated by the Department of Social Services, Office of the Secretary, Bureau of Residential Licensing, LR 33:2694 (December 2007), repromulgated by the Department of Social Services, Office of Community Services, LR 35:1570 (August 2009), amended LR 36:799, 835 (April 2010), repromulgated LR 36:1275 (June 2010), amended by the Department of Children and Family Services, Child Welfare Section, LR 36:2521 (November 2010), amended by

the Department of Children and Family Services, Division of Programs, Licensing Section, LR 38:968 (April 2012), amended LR 41:

§6708. General Provisions

- A. - B.4. ...
- C. Reasonable and Prudent Parent Standard

1. The provider shall designate in writing at least one on-site staff person as the authorized representative to apply the reasonable and prudent parent standard to decisions involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities. The staff person(s) designated as the authorized representative shall be at the licensed location at all times during the facility’s hours of operation. Licensing shall be notified in writing within five calendar days if there is a change to one of the designated representatives.

2. The authorized representative shall utilize the reasonable and prudent parent standard when making any decision involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities.

3. The authorized representative shall receive training or training materials shall be provided on the use of the reasonable and prudent parent standard. Documentation of the reasonable and prudent parenting—training shall be maintained. The reasonable and prudent parent training or training materials, as developed or approved by DCFS, shall include, but is not limited to the following topic areas:

- a. age or developmentally appropriate activities or items;
- b. reasonable and Prudent Parent Standard;
- c. role of the provider and of DCFS; and
- d. allowing for normalcy for the child while respecting the parent’s residual rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1401 et seq.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 38:969 (April 2012), amended LR 41:

Chapter 71. Child Residential Care, Class A

§7105. Definitions

- A. As used in this Chapter:

* * *

Age or Developmentally Appropriate Activities or Items—activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

* * *

Reasonable and Prudent Parent Standard—standard that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities. The standard is characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time

encouraging the emotional and developmental growth of the child.

Reasonable and Prudent Parent Training—training that includes knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities. This includes knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child and knowledge and skills relating to applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities. Activities include sports, field trips, and overnight activities lasting one or more days. Also included is knowledge and skills in decisions involving the signing of permission slips and arranging of transportation for the child to and from extracurricular, enrichment, and social activities.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and R.S. 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Service, LR 36:805 (April 2010), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 38:976 (April 2012), amended LR 41:

§7111. Provider Responsibilities

A. - A.9.a.v. ...

10. Reasonable and Prudent Parent Standard

a. The provider shall designate in writing at least one on-site staff person as the authorized representative to apply the reasonable and prudent parent standard to decisions involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities. The staff person(s) designated as the authorized representative shall be at the licensed location at all times during the facility's hours of operation. Licensing shall be notified in writing within five calendar days if there is a change to one of the designated representatives.

b. The authorized representative shall utilize the reasonable and prudent parent standard when making any decision involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities.

c. The authorized representative shall receive training or training materials shall be provided on the use of the reasonable and prudent parent standard. Documentation of the reasonable and prudent parent training shall be maintained. The reasonable and prudent parent training or training materials, as developed or approved by DCFS, shall include, but is not limited to the following topic areas:

- i. age or developmentally appropriate activities or items;
- ii. reasonable and Prudent Parent Standard;
- iii. role of the provider and of DCFS; and
- iv. allowing for normalcy for the child while respecting the parent's residual rights.

B. - H.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and R.S. 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Service, LR 36:811 (April 2010), amended by the Department of Children and Family

Services, Division of Programs, Licensing Section, LR 38:979, 984 (April 2012), amended LR 41:

Chapter 73. Child Placing Agencies

§7305. Definitions

* * *

Age or Developmentally Appropriate Activities or Items—activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

* * *

Reasonable and Prudent Parent Standard—standard that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities. The standard is characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child.

Reasonable and Prudent Parent Training—training that includes knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities. This includes knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child and knowledge and skills relating to applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities. Activities include sports, field trips, and overnight activities lasting one or more days. Also included is knowledge and skills in decisions involving the signing of permission slips and arranging of transportation for the child to and from extracurricular, enrichment, and social activities.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and ACT 64 of the 2010 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 37:821 (March 2011), amended LR 41:

§7311. Provider Responsibilities

A. - A.7.a.iii. ...

8. Reasonable and Prudent Parent Standard

a. The provider shall designate in writing at least one on-site staff person as the authorized representative to apply the reasonable and prudent parent standard to decisions involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities. The staff person(s) designated as the authorized representative shall be at the licensed location at all times during the facility's hours of operation. Licensing shall be notified in writing within five calendar days if there is a change to one of the designated representatives.

b. The authorized representative shall utilize the reasonable and prudent parent standard when making any

decision involving the participation of a child who is in foster care and placed in the facility in age or developmentally appropriate activities.

c. The authorized representative shall receive training or training materials shall be provided on the use of the reasonable and prudent parent standard. Documentation of the reasonable and prudent parent training shall be maintained. The reasonable and prudent parent training or training materials, as developed or approved by the DCFS, shall include, but is not limited to the following topic areas:

- i. age or developmentally appropriate activities or items;
- ii. reasonable and Prudent Parent Standard;
- iii. role of the provider and of DCFS;
- iv. allowing for normalcy for the child while respecting the parent's residual rights.

B. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and ACT 64 of the 2010 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 37:828 (March 2011), amended LR 41:

§7313. Foster Care Services

A. - B.3.c. ...

d. Documentation of reasonable and prudent parent training for all foster parents shall be maintained. This training shall be completed or training materials provided prior to certification for all foster parents certified after August 31, 2015. All foster parents certified on or prior to September 1, 2015 shall receive training or be provided training materials prior to September 29, 2015. Reasonable and prudent parent training or training materials, as developed or approved by DCFS, shall include, but is not limited to the following topic areas:

- i. age or developmentally appropriate activities or items;
- ii. reasonable and Prudent Parent Standard;
- iii. role of the foster parents and of DCFS;
- iv. allowing for normalcy for the child while respecting the parent's residual rights.

B.4. - C.5.b.vii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and ACT 64 of the 2010 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 37:833 (March 2011), amended by the Department of Children and Family Services, Division of Programs, Licensing Section, LR 38:985 (April 2012), amended LR 41:

§7315. Adoption Services

A. - F.3.b.v.(j). ...

c. Documentation of reasonable and prudent parent training for all adoptive parents shall be maintained. This training shall be completed or training materials provided prior to certification for all adoptive parents certified after August 31, 2015. All adoptive parents certified on or prior to September 1, 2015 shall receive training or be provided training materials prior to September 29, 2015. Reasonable and prudent parent training or training materials, as developed or approved by DCFS, shall include, but is not limited to the following topic areas:

- i. age or developmentally appropriate activities or items;
- ii. reasonable and Prudent Parent Standard;

- iii. role of the adoptive parents and of DCFS;
- iv. allowing for normalcy for the child while respecting the parent's residual rights.

F.4. - J.4.e. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:477 and ACT 64 of the 2010 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Division of Programs, Licensing Section LR 37:842 (March 2011), amended LR 41:

Suzy Sonnier
Secretary

1509#016

DECLARATION OF EMERGENCY

Board of Elementary and Secondary Education

Bulletin 137—Louisiana Early Learning Center Licensing Regulations—Licensure (LAC 28:CLXI.305)

The Board of Elementary and Secondary Education (BESE) has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedure Act, and R.S. 17.6 to amend LAC 28:CLXI.305, Operating Without a License; Registry; Penalties. This Declaration of Emergency, effective June 18, 2015, is being extended beyond the initial period of 120 days and will remain in effect until the final Rule becomes effective.

The law requires BESE to establish statewide minimum standards for the health, safety and well-being of children in early learning centers, ensure maintenance of these standards, and regulate conditions in early learning centers through a program of licensing administered by the LDE. To immediately increase the ability of the Department of Education, local law enforcement and local education agencies to protect children from attending child care centers that are unregulated, BESE has exercised the emergency provision in the adoption of this policy revision.

Title 28

EDUCATION

Part CLXI. Bulletin 137—Louisiana Early Learning Center Licensing Regulations

Chapter 3. Licensure

§305. Operating Without a License; Registry; Penalties

A. Whoever operates any early learning center without a valid license shall be fined by the Licensing Division not less than \$1,000 per day for each day of such offense.

B. If an early learning center is operating without a valid license, the Licensing Division shall file suit for injunctive relief in the district court in the parish in which the center is located to enjoin the owner or operator from continuing the violation.

C. Upon receipt of a court order enjoining an individual from operating an early learning center without a valid, current early learning center license, the department shall notify local law enforcement, the local superintendent, and the early childhood community network lead agency, if different, in the parish in which the unlicensed care was provided, and in the parish in which the individual resides, if

known and different from the parish in which the unlicensed care was provided, of the existence of such a court order.

D. The department shall publish on its website in a statewide registry the names of individuals that have an existing court order prohibiting them from operating an early learning center without a current, valid early learning center license and that do not currently operate a center with a current valid license. The registry shall at a minimum include the name of the individual, the name of the center under which the unlicensed care was provided, and the parish in which the unlicensed care was provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.37.

HISTORICAL NOTE: Promulgated by the Department of Education, Board of Elementary and Secondary Education, amended LR 41:

Charles E. "Chas" Roemer, IV
President

1509#031

DECLARATION OF EMERGENCY

Board of Elementary and Secondary Education

Bulletin 140—Louisiana Early Childhood Care and Education Network (LAC 28:CLXVII.Chapters 1-7)

The Board of Elementary and Secondary Education (BESE) has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedure Act, and R.S. 17.6 to amend LAC 28:CLXVII, Bulletin 140—Louisiana Early Childhood Care and Education Network. This Declaration of Emergency, effective July 1, 2015, is being extended beyond the initial period of 120 days and will remain in effect until the final Rule becomes effective.

Act 3 (Early Childhood Education Act) of the 2012 Regular Legislative Session required the creation of an early childhood care and education network; established the purposes of such network and the related duties and responsibilities of certain state agencies; provided for the development of early childhood education programs and standards; and provided for an accountability system for early childhood education programs. The purpose of Bulletin 140 is to establish the duties and responsibilities of the Early Childhood Care and Education Network, local community networks and community network lead agencies, define kindergarten readiness, and create a uniform assessment and accountability system for publicly-funded early childhood care and education sites and community networks that includes a performance profile indicative of performance.

The unified quality and improvement system will launch with a Learning Year in 2015-2016 whereby every early childhood site and community network will receive a practice performance profile. All publicly-funded early childhood programs will be required to participate, but there will be no funding or licensing consequences attached to the practice performance rating.

Title 28

EDUCATION

Part CLXVII. Bulletin 140—Louisiana Early Childhood Care and Education Network

Chapter 1. General Provisions

§101. Purpose

A. The purpose of this Bulletin is to establish the duties and responsibilities of the Early Childhood Care and Education Network, local community networks and community network lead agencies, define kindergarten readiness, and create a uniform assessment and accountability system for publicly-funded early childhood care and education sites and community networks that includes a performance profile indicative of performance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§103. Definitions

8(g) Program—the Student Enhancement Block Grant Program administered by the Board of Elementary and Secondary Education that provides funding through the Louisiana Education Quality Start Fund that may be used to serve at-risk PreK children.

Assessment—see Early Childhood Care and Education Assessment

At-Risk—Children are considered at-risk if their family income is at or below 185 percent of the Federal Poverty Level according to the United States Department of Agriculture, or if they are in foster care, or they are English language learners, or they are experiencing homelessness, or they meet the definition of an *infant or toddler with a disability* found in 34 C.F.R. §303.21 for children ages birth to three years or a "child with a disability" found in 34 C.F.R. §300.8 for children ages 3 and older.

BESE—Board of Elementary and Secondary Education.

Caregiver—any person legally obligated to provide or secure care for a child, including a parent, legal custodian, foster home parent, or other person providing a residence for the child.

CCAP—Child Care Assistance Program.

Child Care Assistance Program (CCAP)—federal program administered by the Louisiana Department of Education that makes payments to child care providers for child care services provided to eligible families.

CLASS[®]—Classroom Assessment Scoring System.

Classroom Assessment Scoring System (CLASS[®]*)*—a classroom observation-based system used to assess and rate classroom quality across multiple areas using a scale of one to seven.

Classroom—see *Early Childhood Care and Education Classroom*.

Community Network Coverage Area—the geographic area of a community network, which typically is the same geographical area as the local school district or school districts, but may be other coverage areas, as determined by the community network and approved by the department.

Coverage Area—see *Community Network Coverage Area*.

Department—Louisiana Department of Education.

Early Childhood Care and Education Assessment (Assessment)—observation-based process used to determine whether children ages birth to five years are growing and developing across all the areas of development and learning provided in *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*.

Early Childhood Care and Education Classroom (Classroom)—an infant, toddler or PreK classroom.

Early Childhood Care and Education Performance Profile (Performance Profile)—information regarding performance in preparing children for kindergarten that is reported each school year for each publicly-funded site and community network composed of the site or community network’s performance rating and informational metrics.

Early Childhood Care and Education Performance Rating (Performance Rating)—measure of performance in preparing children for kindergarten that is reported each school year for each publicly-funded site and community network.

Early Childhood Care and Education Program (Program)—an early learning center-based or school-based organization that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten.

Early Childhood Care and Education Site (Site)—a distinct early learning center-based or school-based location that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten.

Early Learning Center- any child day care center, early Head Start, Head Start, or stand-alone prekindergarten program that is not attached to a school.

EarlySteps Program—program administered by the Louisiana Department of Health and Hospitals that provides early intervention services for infants and toddlers with disabilities ages birth to three years and their families according to the requirements of the Individuals with Disabilities Education Act (IDEA), Part C.

Equitable Access—the point at which every family who wishes to enroll their at-risk child in a publicly-funded program is able to do so.

Fall Observation Period—observation period between August 1 and December 15 of each year.

Fiscal Year—July 1-June 30.

Full Day—at least six continuous hours per day or more than 20 hours per week of care and instruction aligned with a typical school day.

Head Start and Early Head Start Programs—federally-funded early childhood care and education programs that promote and teach school readiness to children ages birth to five from low-income families and provide services in the areas of education, social services for families, nutrition, family engagement, health and mental health, as well as providing the physical plant and instructional staff members for such purposes (42 U.S.C. 9801 et seq., 45 C.F.R Part 1300).

Individuals with Disabilities Education Act (IDEA), Part B—federal program administered by the Louisiana Department of Education that provides education funding for children with disabilities, ages 3 through 21.

Individuals with Disabilities Education Act (IDEA), Part C—federal program administered by the Louisiana Department of Health and Hospitals that provides early intervention services for infants and toddlers with disabilities ages birth to three years and their families to meet the developmental needs as identified by the individualized family services plan. See *EarlySteps Program*.

Infant—a child who has not yet reached 15 months of age.

Infant Classroom—a classroom in which the majority of children are infants.

Informational Metric—measure of early childhood care and education best practices at the site or community network level.

LA 4 Program—the Cecil J. Picard LA 4 Early Childhood Program that provides funding for PreK classrooms for four-year-old children who are eligible to enter kindergarten the following school year.

Lead Teacher—the early childhood care and education classroom teacher that is primarily responsible for the classroom and is required to meet the certification requirements in *Bulletin 746—Louisiana Standards for State Certification of School Personnel*.

Learning Year—the 2015-2016 school year shall be a learning year for the Early Childhood Care and Education Network.

Nonpublic School Early Childhood Development Program (NSECD)—Louisiana program administered by the Department of Education that provides funding for four-year-old preschool in BESE-approved nonpublic schools and Type III early learning centers.

Notice—written notice is considered given:

1. when it is sent by email or fax to the last email address or fax number furnished to the department;
2. when it is hand-delivered; or
3. on the fifth calendar day after it was mailed to the last mailing address furnished to the department.

NSECD—Nonpublic School Early Childhood Development Program.

Performance Profile—see *early childhood care and education performance profile*.

Performance Rating—see *early childhood care and education performance rating*.

PreK—prekindergarten.

PreK Child—a child age 36 months to 5 years who has not yet entered kindergarten.

PreK Classroom—a classroom in which the majority of children are PreK children.

Program—see *Early Childhood Care and Education Program*.

Publicly-Funded Children—children ages birth to five years who have not yet entered kindergarten that are being served full day with funds from either CCAP, Early Head Start, Head Start, LA 4 Program, NSECD, 8(g) block grant, title 1 of ESEA, or IDEA part B in a full day setting.

Publicly-Funded Classroom—see *publicly-funded early childhood care and education classroom*.

Publicly-Funded Program—see *Publicly-Funded Early Childhood Care and Education Program*.

Publicly-Funded Site—see *publicly-funded early childhood care and education site*.

Publicly-Funded Early Childhood Care and Education Classroom—any infant, toddler or PreK classroom that includes a publicly-funded child or children.

Publicly-Funded Early Childhood Care and Education Program—an early learning center-based or school-based organization that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten with funds from either CCAP, Early Head Start, Head Start, NSECD, LA 4 Program, 8(g) block grant, title 1 of ESEA or IDEA part B, or that is authorized to receive CCAP, or that participates in the quality start child care rating system.

Publicly-Funded Early Childhood Care and Education Site—a distinct early learning center-based or school-based location that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten in a full-day setting with funds from either CCAP, Early Head Start, Head Start, NSECD, LA 4 Program, 8(g) block grant, title 1 of ESEA or IDEA part B, or that is authorized to receive CCAP, or that participates in the quality start child care rating system.

Site—see *early childhood care and education site*.

Spring Observation Period—observation period between January 1 and May 15 of each school year.

State Superintendent—state superintendent of education.

Third Party Independent Contractor (Third Party Contractor)—contractor that is separate from and independent of the lead agency and the community network with whom the department enters into a contract to perform CLASS observations on behalf of the department.

Title I—title I of the Elementary and Secondary Education Act (ESEA) that provides funding that may be used for preschool programs for disadvantaged children.

Toddler—a child age 15 months to 36 months.

Toddler Classroom—a classroom in which the majority of children are toddlers.

Type III Early Learning Center—an early learning center that directly or indirectly receives state or federal funds from any source other than the federal food and nutrition programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.23 and R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 3. Early Childhood Care and Education Network

§301. Early Childhood Care and Education Network

A. The Early Childhood Care and Education Network is established as the comprehensive and integrated network through which the Board of Elementary and Secondary Education (BESE) manages and oversees publicly-funded early childhood care and education programs in Louisiana to promote and improve kindergarten readiness.

B. The Early Childhood Care and Education Network is comprised of the local community networks throughout the state.

C. The Department of Education (department), pursuant to authority delegated by BESE, manages and oversees the administration of the Early Childhood Care and Education Network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§303. BESE's Duties and Responsibilities

A. To facilitate the creation of the Early Childhood Care and Education Network, BESE shall:

1. establish a definition of kindergarten readiness aligned with Louisiana content standards for elementary and secondary schools (see §305 of this Chapter);

2. establish performance targets for children under the age of three and academic standards for kindergarten readiness for three- and four-year old children to be used in publicly-funded early childhood education programs (see *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*);

3. create a uniform assessment and accountability system for publicly-funded early childhood care and education programs that includes an early childhood care and education performance rating (performance rating) indicative of performance (see Chapter 5 of this bulletin);

4. align the standards for the licensing of child care facilities, including the requirements for participation in the Louisiana quality start child care rating system, with the standards established for early childhood education programs (see *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Standards* and *Bulletin 139—The Louisiana Child Care and Development Fund Programs*).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§305. Kindergarten Readiness Definition

A. Children who are ready for kindergarten are expected to demonstrate:

1. cognitive abilities, which include knowledge and skills in:

a. early literacy, such as phonological awareness, print concepts, alphabetic understanding, vocabulary, listening comprehension, and emergent writing;

b. basic numeracy concepts, such as rote counting and number awareness, sorting, classifying, comparing, patterning, and spatial relationships;

2. basic science concepts, such as making observations, exploring the world using their senses, and using appropriate scientific vocabulary related to topics;

3. basic social studies concepts, such as self-awareness and their relationship to family and community, and an awareness of money and time;

4. response to and participation in music, movement, visual and dramatic arts experiences and activities;

5. abilities, either assisted or unassisted, that show an awareness of health, hygiene, and environmental hazards, in addition to gross and fine motor skills;

6. social and emotional competencies, including self-regulation, self-identity, self-reliance, respect for others, and interpersonal skills; and

7. approaches to learning, such as reasoning and problem-solving, engagement, persistence, and eagerness to learn.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§307. Publicly-Funded Early Childhood Care and Education Programs and Community Networks

A. Publicly-funded Early Childhood Care and Education Program (Publicly-Funded Program)

1. Each publicly-funded program shall participate in the:

a. membership in the community network for its coverage area;

b. early childhood care and education accountability system (accountability system), as provided in Chapter 5; and

c. coordinated enrollment process, as provided in Chapter 7.

2. Any publicly-funded program that does not comply with Paragraph A.2 of this Section may be subject to the loss of its public funding.

B. Community Network

1. Each community network shall:

a. participate in the early childhood care and education accountability system (accountability system);

b. develop and implement a coordinated observation plan for the community network;

c. develop and implement a coordinated enrollment process for the community network;

d. have a lead agency;

e. support the department in disseminating and collecting an annual survey from lead teachers and families of every publicly-funded child; and

f. address other needs as identified by the community network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§309. Community Network Lead Agency

A. A community network lead agency is either a state agency, a local public school system, a non-profit or for-profit corporation having an educational or social services mission, including but not limited to a nonprofit corporation of a philanthropic or policy nature, a Louisiana public postsecondary institution, or a nonprofit corporation established by the governing authority of a parish or municipality, that is approved by BESE and that:

1. serves as the fiscal agent of the community network;

2. coordinates the duties and responsibilities of the community network; and

3. acts as the liaison between the community network and the department.

B. Duties and Responsibilities

1. The lead agency shall be responsible for coordinating the duties and responsibilities of the community network pertaining to:

a. coordinated Classroom Assessment Scoring System (*CLASS*) observations, as provided in §503, which includes but is not limited to:

i. submitting the community network's annual plan for coordinated *CLASS* observations to the department;

ii. submitting all *CLASS* observation results to the department; and

iii. sharing each publicly-funded program's *CLASS* observation results with that publicly-funded program and sharing the aggregate *CLASS* observation results for the community network with all publicly-funded programs in the community network, at least monthly;

b. coordinated enrollment, as provided in Chapter 7, which includes but is not limited to:

i. ensuring a coordinated enrollment process is operated by the community network each year as provided in §703;

ii. submitting to the department the community network's coordinated enrollment plan, which shall include signatures from each publicly-funded program in the community network indicating approval of the plan and shall describe how the community network will ensure coordinated enrollment for families within the community network who want to enroll their infant, toddler, or PreK children in a publicly-funded program in the community network;

iii. submitting counts to the department twice a year reflecting the total enrollment of at-risk children in all programs in the community network as of October 1 and as of February 1, according to the age cohorts provided in §701;

iv. submitting an annual request for funding to the department for publicly-funded programs in the community network that is based on the results of the coordinated enrollment process used in the community network and is subject to the requirements provided in §709; and

v. working with all publicly-funded programs in the community network to maximize all available resources to increase the quality of and access to the publicly-funded programs for at-risk children;

c. accountability system reporting, as provided in §515;

d. data verification, as provided in §517;

e. requesting waivers, as provided in §519;

f. submitting appeals, as provided in §521; and

g. demonstrating progress toward implementation of coordinated enrollment as provided in §707.

2. The lead agency shall not charge any publicly-funded program for any part of the coordinated observation process and shall not require publicly-funded programs to provide staff to conduct *CLASS* observations.

C. Selection and Approval

1. Lead agencies shall be approved by BESE.

2. The department shall identify potential lead agencies through a competitive process and submit them to BESE for approval.

2. Applicants for lead agency shall demonstrate support from all publicly-funded programs within the community network by obtaining signatures from each and submitting them to the department in the competitive process.

3. By June 30 of each year, the department shall recommend the identified lead agencies to BESE for approval.

4. If BESE has not approved a lead agency for a community network by July 1, the department shall serve as lead agency for the community network.

5. Lead agencies approved by BESE shall serve for the fiscal year beginning July 1 and ending June 30.

D. Contracts

1. Lead agencies approved by BESE shall enter into a lead agency agreement with the department.

2. The lead agency may enter into a contract or agreement with an individual or entity for performance of specific tasks within the duties and responsibilities of the lead agency, but the lead agency remains responsible for satisfactory completion of the tasks.

E. Funding

1. Subject to available funding, lead agencies shall be funded based on the number of early childhood care and education classrooms (classrooms) in the network.

a. Lead agencies shall be notified of their total funding for the following fiscal year by June 30.

b. Lead agencies shall use funding solely to fulfill the duties and responsibilities of the community network as provided in this bulletin.

c. If the department is required to serve as a lead agency, the department shall be funded in the same manner as any other lead agency.

F. Audit

1. BESE may request a financial audit of the lead agency's use of funds allocated to it.

2. Audits shall be at the department's expense.

3. If a lead agency improperly uses its allocated funds, the lead agency may be required to repay the improperly used amount.

G. Termination of Lead Agency Approval

1. If a lead agency fails to satisfactorily and timely comply with the duties and responsibilities contained in this Bulletin or with any additional duties and responsibilities established in writing during the competitive process, the department shall notify the lead agency, and all publicly-funded programs within the community network in writing and specify any corrective actions that may be required.

2. Within 30 calendar days of receiving such notice, the lead agency shall submit in writing to the department certification that the corrective actions have been taken or are in the process of being taken and submit a timely implementation schedule for department approval.

3. If the lead agency does not respond in writing in a timely or satisfactory manner or adhere to the implementation schedule approved by the department, either or both of the following actions may occur:

a. The department may withhold funds from the lead agency for any work not yet performed.

b. The department may make a recommendation to BESE that approval of the lead agency be terminated.

4. If BESE terminates a lead agency's approval and does not approve a new lead agency, the department shall serve as lead agency for a community network.

5. The department shall notify all publicly-funded programs in a community network of any change in that community network's lead agency.

6. If a lead agency's approval is terminated:

a. The entity shall be ineligible to serve as lead agency in the community network from which its approval was terminated for a minimum period of 24 months.

b. If the entity serves as lead agency for more than one community network, the entity may continue to serve as

lead agency for any community network for which its approval has not been terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§311. Complaints

A. Any program or individual may submit a written complaint to the department regarding the action or inaction of the lead agency in its community network.

B. A complaint shall be submitted in writing within 30 calendar days of the action or inaction of the lead agency upon which the complaint is based.

C. All complaints shall clearly state the action or inaction upon which the complaint is based and provide specific facts and documentation supporting the complaint.

D. The department shall act upon and respond in writing to all signed complainants within 30 calendar days of receiving the complaint.

E. Anonymous complaints may be acted upon at the discretion of the department.

F. Lead agencies shall not retaliate in any manner against a program or individual that submits a complaint to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§313. Academic Approval for Type III Early Learning Centers

A. All type III early learning centers shall meet the performance and academic standards of the Early Childhood Care and Education Network regarding kindergarten readiness as provided in R.S. 17:407.36(C).

B. Type III early learning centers meeting the performance and academic standards shall receive academic approval from the department. Academic approval is verification by the department that the center is meeting the required performance and academic standards.

C. Initial Academic Approval for 2015-2016 Fiscal Year

1. Existing Type III Early Learning Centers

a. Academic approval shall be granted for the 2015-2016 fiscal year to any existing type III early learning center that has submitted a signed copy of program partner profile and assurances (assurances) to the lead agency of the community network in its area, and is thereby agreeing to:

i. membership in the community network;

ii. participation in the early childhood care and education accountability system, as provided in Chapter 5; and

iii. participation in the coordinated enrollment process, as provided in Chapter 7,

b. The community network shall submit copies of assurances signed by type III early learning centers to the department within seven calendar days of receiving them or prior to July 1, 2015, whichever is earlier.

c. The department shall send written notice of academic approval to each type III early learning center that has submitted signed assurances to its community network in compliance with Paragraph C(1)(a) by July 1, 2015.

2. Applicants for new Type III Early Learning Center Licenses

a. In order to obtain the initial academic approval required to be licensed as a type III early learning center, an applicant for a type III early learning center license must become a member of the community network in its coverage area and submit a signed copy of the program partner profile and assurances (assurances) to the lead agency of the community network thereby agreeing to:

- i. membership in the community network;
- ii. participation in the early childhood care and education accountability system, as provided in Chapter 5; and
- iii. participation in the coordinated enrollment process, as provided in Chapter 7,

b. The department shall send written notice of academic approval to each type III early learning center that has submitted signed assurances to its community network in compliance with Subparagraph C.2.a within 30 days of receipt of the signed assurances.

D. Academic approval shall be valid for the fiscal year, July 1-June 30, for which it is granted.

E. Academic approval is granted to a specific owner and a specific location and is not transferable. If a type III early learning center changes owners or location, it is considered a new operation, and academic approval for the new owner or location must be obtained prior to beginning operations under new ownership or at the new location.

F. Upon a change of ownership or change of location, the academic approval granted to the original owner or at the original location becomes null and void.

G. Renewal

1. Prior to July 1 of each year, the department shall send notice to each type III early learning center that has academic approval providing one of the following:

- a. renewal of academic approval for the center;
- b. notice of the center's failure to comply with specific requirements in Subsection A and specific corrective actions that must be taken by a specified date in order for academic approval to be renewed; or
- c. if an early learning center has received the notice outlined in Subparagraph H.2.a of this Section within the academic year and the center has not provided the required certifications and completed the stated corrective actions, the department may terminate the center's academic approval as provided in Subparagraph H.2.c and send notice of termination of the center's academic approval.

H. Termination of Academic Approval

1. The department may terminate academic approval for:

- a. violations of any provisions of this Bulletin related to the performance and academic standards of the Early Childhood Care and Education Network;
- b. failure to timely comply with a corrective action plan provided by the department; or
- c. any act of fraud, such as the submission of false or altered documents or information.

2. Notice

a. If a type III early learning center is in violation of any provision in Subsection A, the department shall notify the center in writing and may specify any corrective actions that shall be required to retain academic approval.

b. Within 30 calendar days of receiving such notice, the center shall submit certification in writing to the department that the corrective actions have been taken or are in the process of being taken in compliance with the schedule provided and certification that the center will remain in compliance with all applicable regulations.

c. If the type III early learning center does not respond in a timely or satisfactory manner or adhere to the implementation schedule for required corrective actions, the department may terminate the center's academic approval by sending written notice of termination to the center.

d. Termination of the center's academic approval shall be effective when notice of termination is given.

I. Appeal Procedure

1. BESE shall have the authority to grant an appeal of the termination of a type III early learning center's academic approval.

2. The appeal procedure shall be used when needed to address unforeseen and aberrant factors impacting type III early learning centers or when needed to address issues that arise when the literal application of the academic approval regulations does not consider certain unforeseen and unusual circumstances.

3. A type III early learning center may request an appeal of the termination of its academic approval by submitting a written request for an appeal to the department within 15 calendar days of being given notice of termination of its academic approval.

4. All appeal requests shall clearly state the specific reasons for requesting the appeal and the reasons why the appeal should be granted and shall include any necessary supporting documentation.

5. The department shall review all timely submitted appeal requests and make recommendations to BESE during the first regularly scheduled BESE meeting following receipt of the appeal requests, or during the second regularly scheduled BESE meeting if an appeal request is received within 10 working days of the next regularly scheduled BESE meeting. Within this interval, the department shall notify the center of its recommendation and allow the center to respond in writing. The department's recommendation and the center's response shall be submitted to BESE for final disposition.

6. An early learning center that appeals the termination of its academic approval shall retain its academic approval during the appeal process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.36(C) and R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 5. Early Childhood Care and Education Accountability System

§501. Early Childhood Care and Education Accountability System (Accountability System)

A. The Early Childhood Care and Education Accountability System (accountability system) is the uniform accountability system created pursuant to R.S. 17:407.23(B)(3) and used to evaluate the performance of publicly-funded early childhood care and education sites and community networks in preparing children for kindergarten

and to assign a performance profile to each site and community network.

B. Participants

1. Publicly-funded Early Childhood Care And Education Sites (Publicly-Funded Sites)

a. All publicly-funded sites with at least one classroom on October 1 shall participate and shall be included in the accountability system.

b. All publicly-funded sites with at least one classroom on October 1 and one classroom on February 1 shall participate and shall receive a performance profile for the school year.

c. All classrooms in existence on either October 1 or February 1 in a publicly-funded site shall be included in the accountability system for that school year.

d. Publicly-funded sites that open after October 1 of a school year shall not participate in the accountability system, as provided in this Chapter, until the start of the following school year.

2. Community Networks

a. All community networks shall participate and shall be included in the accountability system and shall receive a performance profile for the school year.

b. If any publicly-funded site discontinues participation in a community network after October 1 by changing funding source, license type, or closing, its performance shall remain part of the community network performance profile for the school year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§503. Coordinated Observation Plan and Observation Requirements

A. Coordinated observation is the local process by which each community network ensures that every classroom in a publicly-funded site in the community network receives two *CLASS* observations each school year.

B. *CLASS* Observation Requirements

1. A *CLASS* observation is an observation of a classroom using the appropriate toddler or PreK *CLASS* using all domains, typically occurring during the morning, in which a reliable observer conducts four twenty-minute cycles of observation and note-taking followed by at least ten minutes of scoring after each observation cycle.

2. Domains and Dimensions

a. *CLASS* observations for toddler classrooms shall include both toddler *CLASS* domains, which are emotional and behavioral support and engaged support for learning, and all dimensions contained within.

b. *CLASS* observations for PreK classrooms shall include all three PreK *CLASS* domains, which are emotional support, classroom organization, and instructional support, and all dimensions contained within.

3. Required Observations

a. All toddler and PreK classrooms in a publicly-funded site shall receive two *CLASS* observations during the school year conducted by the community network.

b. One observation shall occur during the fall observation period, if the classroom is in existence on October 1, and the other shall occur during the spring observation period, if the classroom is in existence on February 1.

c. *CLASS* observations conducted by third party contractors hired by the department shall not count towards this requirement.

4. Use of Toddler or PreK *CLASS*. Classrooms shall be observed with the same *CLASS* throughout the school year based on the composition of the classroom when the observation plan required in §503.C is submitted according to the following.

a. A classroom that only has infant children or a classroom that has a mix of infant and toddler children in which a majority are infant children shall not be observed.

b. A classroom that has all toddler children or a classroom that has a mix of infant and toddler children in which the majority are toddler children shall be observed with the toddler *CLASS*.

c. A classroom that has all PreK children or a classroom that has a mix of toddler and PreK children in which the majority are PreK children shall be observed with the PreK *CLASS*.

C. Coordinated Observation Plan

1. Each community network shall submit for department approval no later than September 30 a written annual plan for coordinated observation using *CLASS* that at a minimum includes:

a. the number of *CLASS* observers who will conduct observations;

b. the total number and the location of toddler and PreK classrooms that must be observed;

c. an observation schedule that includes two observations for each toddler and PreK classroom identified in Subparagraph B.3.b of this Section, with one observation scheduled during the fall observation period and one during the spring observation period; and

d. a plan to ensure reliable data that includes the following requirements:

i. All observers are reliable, which is defined as all observers having a certification achieved by completing and passing all trainings and assessments required by Teachstone to conduct a *CLASS* observation with validity and fidelity;

ii. All observers maintain inter-rater reliability and fidelity. Inter-rater reliability occurs when two or more observers produce consistent observation results for the same classroom at the same time;

iii. The community network conducts inter-rater reliability observation checks for 10 percent of all classrooms observed; and

iv. No observer shall conduct an observation in which the observer is an immediate family member, as defined in R.S. 42:1101, of a teacher in the classroom being observed or an immediate family member of an individual who supervises or provides training or technical assistance to a teacher in the classroom being observed or has a direct financial interest in the site where the classroom is being observed.

D. Waiver

1. The state superintendent of education shall have the authority to grant waivers to lead agencies for specific requirements of the coordinated observation plan or observation requirements included in this Chapter, with the exception of C.1.d.iv.

2. Lead agencies seeking a waiver shall submit a written request the department prior to or at the time of the submission of the coordinated enrollment plan. The request shall cite the specific requirement for which a waiver is being requested and shall clearly state the reasons why the waiver is being requested and why it should be granted. Waiver requests shall include any supporting documentation that substantiates the need for the waiver.

3. The department shall respond in writing to waiver requests within 30 calendar days after receiving the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§505. Performance Profiles

A. The performance profiles for publicly-funded sites and for community networks shall include:

1. a performance rating as provided in §509 for publicly-funded sites and as provided in §511 community networks, and

2. informational metrics as provided in §513.

B. Each publicly-funded site and each community network shall receive a performance profile based on performance each school year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§507. Performance Profile Implementation Timeline

A. The 2015-2016 school year shall be a learning year for publicly-funded sites and community networks.

1. A learning year is a year in which there are no consequences on publicly-funded sites or community networks as a result of their performance profile.

2. Performance profiles for the 2015-2016 learning year shall clearly indicate that the performance profile is practice and is from a learning year.

B. Every publicly-funded site, except those that begin operating after October 1, and every community network shall participate in the accountability system for the 2015-2016 learning year and shall receive a practice performance profile as provided in §501.

1. Type III early learning centers that do not participate in the accountability system may have their academic approval terminated.

2. All other publicly-funded sites that do not participate in the accountability system may be subject to the loss of public funding.

C. The 2016-2017 school year shall be the first school year in which publicly-funded sites and community networks are accountable for the performance rating earned.

D. Prior to the start of the 2016-2017 school year, BESE shall review this Chapter and revise as necessary based on learnings from the 2015-2016 learning year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§509. Performance Rating Calculations for Publicly-Funded Sites

A. The performance rating for each publicly-funded site shall be based on the average of the domain level toddler and

PreK observation results from the fall and spring observation periods for all toddler and PreK classrooms within the site.

1. BESE may include a weight for improvement beginning with the 2016-2017 school year.

B. Any classroom in a publicly-funded site that does not have the observations required in §503 or does not have all results reported, shall have a score of one assigned to each missing CLASS domain score. The score of one for missing or not-reported observation results shall be included in the performance rating calculation for that site and the number of missing or not-reported observation results shall be reported on the performance profile.

1. Lead agencies may have their approval terminated as provided in §309.G for incomplete observations or observation results not reported.

2. Any site or program that has diligently sought observations from the lead agency, including written evidence of such efforts, and that has not been provided such observations, may request of BESE an appeal of its performance rating as described in §521. BESE shall consider diligent efforts and evidence thereof in determining the appeal.

3. Prior to the issuance of the publicly-funded site or community network profiles, the department shall provide to the Advisory Council on Early Childhood Care and Education committee members and to BESE members a list of all publicly funded sites receiving a score of one due to a missing or not-reported CLASS domain score and the number of such ones received by each site.

C. The department shall compare the domain level results from observations of classrooms conducted by the department's third-party contractors to the domain level results from observations conducted by the community network for each publicly-funded site.

1. In calculating the performance rating, the department shall replace domain level results from classroom observations conducted by community networks with the domain level results from observations conducted by the department's third-party contractors for any single domain in which the results differ by more than one point and shall calculate the performance rating using the replaced results.

2. The department shall monitor the domain level observation results of classroom observations conducted by community networks for each publicly-funded site, including by observer, and domain level observation results conducted by the department's third-party contractor for each publicly-funded site.

a. For the 2015-2016 learning year, if the observation results conducted by community networks are consistently different by more than one point from observation results conducted by the department's third-party contractors, the department may replace all of the community network's observation results for a publicly-funded site with the results from the department's third-party contractors, including those results that do not differ by at least one point.

b. The department shall review results from the 2015-2016 learning year and recommend policy to BESE for 2016-2017 and beyond.

D. The performance rating for each site shall be based on the following numerical scale:

1. 6.0-7.0—excellent;
2. 3.0-5.99—proficient;
3. 1.0-2.99—needs improvement.

E. The numerical scale and performance rating shall be used for each CLASS domain and for the overall performance rating.

F. BESE may transition to a five level rating scale beginning with the 2017-2018 school year.

G. BESE shall review the overall rating calculation, including but not limited to data collected on the informational metrics of best practices, prior to the 2016-2017 school year and determine whether additional factors should be added to the rating calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§511. Performance Rating Calculations for Community Networks

A. The performance rating for a community network shall be calculated as follows.

1. CLASS observation results shall be 50 percent of a community network performance rating.
2. An equitable access score for four-year-olds shall be 50 percent of the community network performance rating.
3. BESE may include a weight for improvement on equitable access beginning with the 2016-2017 school year.

B. The CLASS observation results shall be determined by averaging the results of all fall and spring domain level toddler and PreK observation results for all toddler and PreK classrooms within the community network.

1. Any classroom in a site that does not have the observations required in §503, or has not had all observation results reported, shall have a score of one assigned to each missing CLASS domain. The score of one for missing observation or not-reported results shall be included in the performance rating calculation for the community network and the number of missing or not-reported observation results shall be reported on the community network's performance profile.

a. Lead agencies may be subject to termination as provided in §309.G for incomplete observations or observation results not reported.

2. The department shall compare the domain level results from observations of classrooms conducted by the department's third party contractors to the domain level results from observations conducted by community network for each publicly-funded site.

a. In calculating the performance rating, the department shall replace domain level results from classroom observations conducted by community network with the domain level results from observations conducted by the department's third party contractor for any single domain in which the results differ by more than one point and shall calculate the performance rating using the replaced results.

b. The department shall monitor domain level observation results of classroom observations conducted by community network for each publicly-funded site, including by observer, and domain level observation results conducted

by the department's third party contractors for each publicly-funded site.

i. For the 2015-2016 learning year, if the observation results conducted by a community network are consistently different by more than one point from observation results conducted by the department's third party contractor, the department may replace all of the community network's observation results for a publicly-funded site with the results from the department's third party contractor for that site, including those results that do not differ by at least one point.

ii. The department shall review results from the 2015-2016 school learning year and recommend policy to BESE for 2016-2017 and beyond.

C. The equitable access score shall be determined by calculating the access achieved by the community network for all at-risk four-year-old children in the community network coverage area. Points are earned on a seven point scale according to:

Percentage of At-Risk Four-Year-Olds Served	Points
95-100 percent	7
90-94.9 percent	6
85-89.9 percent	5
80-84.9 percent	4
75-79.9 percent	3
70-74.9 percent	2
0-69.9 percent	1

D. The performance rating for each community network shall be based on the following numerical scale:

1. 6.0-7.0—excellent;
2. 3.0-5.99—proficient;
3. 1.0-2.99—needs improvement.

E. The numerical scale and performance rating shall be used for reporting each CLASS domain and the overall performance rating.

F. BESE may transition to a five level rating scale beginning with the 2017-2018 academic year.

G. BESE shall review the overall rating calculation, including but not limited to data collected on the informational metrics of best practices, prior to the 2016-2017 school year and determine whether additional factors should be added to the rating calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§513. Informational Metrics of Best Practices

A. Informational metrics are measures of a publicly-funded site and a community network's use of the following early childhood care and education best practices:

1. Child Assessment that Informs Instruction

a. Ready to Assess. Publicly-funded sites ensure all lead teachers have certification of reliability as provided by the assessment creator for each school year.

b. Ongoing Assessment. Publicly-funded sites ensure all publicly-funded children receive completed assessments in October, February, and May. Publicly-funded sites shall obtain approval from the department prior to using child assessment tools different from the assessment tool provided by the department.

c. Assessing Accurately. Publicly-funded sites ensure there is an assessment portfolio for every publicly-funded child that provides evidence of the assessment rating for that school year.

2. Investment in Quality Measures

a. Teacher/Child Ratios. Publicly-funded sites maintain teacher/child ratios based on the age of children that are at or better than the minimum standards required in BESE *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Standards*.

i. To achieve gold level ratios, publicly-funded sites use the following teacher/child ratios and group sizes.

Age	Teacher/Child Ratio	Maximum Group Size
Birth to 1 year	1:4	8
1 year to 2 years	1:4	8
2 years to 3 years	1:6	12
3 years to 4 years	1:8	16
4 years to 5 years	1:10	20

ii. To achieve silver level ratios, publicly-funded sites use the following teacher/child ratios and group sizes.

Age	Teacher/Child Ratio	Maximum Group Size
Birth to 1 year	1:4	8
1 year to 2 years	1:6	12
2 years to 3 years	1:8	16
3 years to 4 years	1:10	20
4 years to 5 years	1:12	24

iii. To achieve bronze level ratios, publicly-funded sites use the minimum ratio standards required in BESE *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Standards*.

a. Teacher Preparation. Publicly-funded sites ensure lead teachers meet or exceed credential requirements for publicly-funded classrooms provided in BESE *Bulletin 746—The Louisiana Standards for State Certification of School Personnel*.

b. Standards-Based Curriculum. Publicly-funded sites use a curriculum that is aligned to BESE *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*.

3. Family Engagement and Supports

a. Publicly-funded sites and community networks engage families and ensure families are satisfied with their children’s care and education experience, as measured through a family survey that will be produced and managed by the department

4. Community Network Supports (reported at the community network level only)

a. Community networks ensure teachers have access to supports to address their professional development needs and aid them in supporting children’s learning and development.

b. Community networks and publicly-funded sites ensure children are prepared for kindergarten.

B. The performance profile shall report the publicly-funded site and community network’s use of the best

practices identified in Subsection A by reporting the following informational metrics:

1. Child Assessment that Informs Instruction

a. Ready to Assess—the percent of reliable lead teachers in each site and community network;

b. Ongoing Assessment—the percent of publicly-funded children who receive at least three assessments per school year in each program and community network; and

c. Assessing Accurately—the level to which assessment portfolios substantiate the assessment ratings for publicly-funded children in each site and community network.

2. Investment in Quality Measures

a. Teacher/Child Ratios—the level of ratios used: gold, silver, or bronze;

b. Prepared Teachers—the percent of lead teachers holding varying levels of academic credentials and teacher certification for each site and community network; and

c. Standards-Based Curriculum—the extent to which the curriculum in use by a site is aligned to the early learning and development standards contained in BESE *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*.

3. Family Engagement and Supports

a. for each site, the level of satisfaction community network families have reported with the site; and

b. for each community network, the level of satisfaction community network families have reported with the coordinated enrollment process.

4. Community Network Supports (reported at the community network level only)

a. the level of satisfaction lead teachers have reported with the supports received from the community network; and

b. the percent of publicly-funded four-year-old children that are kindergarten ready at the beginning and end of the school year based on results from the child assessment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§515. Reporting for the Accountability System

A. Lead agencies shall report to the department, in the manner specified by the department, the following:

1. classroom counts:

a. by October 31, the number of classrooms serving infant, toddler and PreK children in each publicly-funded site on October 1;

b. by February 28, the number of classrooms serving infant, toddler, and PreK children in each publicly-funded site on February 1; and

c. by February 28, the number of classrooms in the February 1 count that have been added or removed since the October 1 count;

2. child counts:

a. by October 31, the number of publicly-funded children in each publicly-funded site on October 1;

b. by February 28, the number of publicly-funded children in each publicly-funded site on February 1; and

c. by February 28, the number of publicly-funded children by site in the February 1 count that have been added or removed since the October 1 count;

3. CLASS observation results:

a. within 10 business days after the observation, unless upon written request from the lead agency, the department grants a written extension of time for a specific observation based on the extenuating circumstances provided in the written request;

b. all fall observation period data by December 15; and

c. all spring observation period data by May 15;

4. child assessment results for publicly-funded infants, toddlers and PreK children by October 31, February 28, and May 31.

B. Publicly-funded sites shall report to the department by October 31, in the manner specified by the department, the following:

1. number of lead teachers with certification of reliability on the ongoing assessment used in the community network;

2. teacher/child ratios used in the site;

3. credential and certification status of each lead teacher; and

4. curriculum used in each classroom.

C. The department shall report to lead agencies on a monthly basis the number of CLASS observations that have been submitted for publicly-funded programs in that community network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§517. Data Verification

A. The department shall provide all non-survey data contributing to the performance profile for publicly-funded sites and community networks to each Lead Agency prior to publishing the performance rating.

B. The department shall provide lead agencies 30 calendar days for final review, correction, and verification of data for the performance profiles.

1. The lead agency shall create and implement a community network data certification procedure that requires review of all performance profile data for each site during the data certification period.

2. The department may request the certification procedure from each lead agency.

3. All data correction must take place during the 30 calendar day period.

4. Data corrections may be submitted for the following reasons:

a. CLASS observations results have been reported incorrectly; or

b. CLASS observation results were not reported.

5. The department shall review all data corrections and grant approval of those corrections that are proven valid.

6. The department may request additional documentation to support the validity of the changes.

C. The department shall act upon and respond in writing within 30 calendar days of receiving a signed report from the

general public regarding potential irregularities in data reporting.

D. Anonymous complaints may be acted upon at the discretion of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§519. Waivers of Accountability System Requirements

A. The state superintendent of education (state superintendent) shall have the authority to grant waivers to publicly-funded sites and community networks for specific requirements of the accountability system included in this Chapter.

1. Community Networks

a. Prior to October 1, any lead agency requesting a waiver on behalf of the community network from a requirement of the accountability system shall submit a request in writing to the department.

b. After October 1 and prior to the start of the data verification period established in §517, any lead agency with extenuating circumstances arising after October 1 may request a waiver by submitting a written request to the department that shall clearly state the extenuating circumstances on which the request is based.

2. Publicly-Funded Sites

a. Prior to October 1, any publicly-funded site requesting a waiver from a requirement of the accountability system shall submit a request in writing to the department and shall include a written statement of support for the waiver from the community network lead agency.

b. After October 1 and prior to the start of the data verification period established in §517, any publicly-funded site with extenuating circumstances arising after October 1 may request a waiver by submitting a written request to the department that shall clearly state the extenuating circumstances on which the request is based. The request shall include a written statement of support for the waiver from the community network lead agency.

B. All waiver requests shall cite the requirement(s) from which a waiver is being requested and shall clearly state the reasons why it being requested and why it should be granted. Waiver request shall include any supporting documentation that substantiates the need for the waiver.

C. The department shall respond in writing to waiver requests within 30 calendar days after receiving the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§521. Performance Profile Appeals Procedure

A. BESE shall have the authority to grant an appeal of a publicly-funded site or community network's performance profile.

B. The appeal procedure shall be used when needed to address unforeseen and aberrant factors impacting publicly-funded sites and community networks or when needed to address issues that arise when the literal application of the accountability system regulations does not consider certain unforeseen and unusual circumstances.

C. A publicly-funded site or community network may request an appeal of its performance profile by submitting a

written request for an appeal to the department within 15 calendar days of the department's release of the publicly-funded site or community network's performance profile.

D. All appeal requests shall clearly state the specific reasons for requesting the appeal and the reasons why the appeal should be granted and shall include any necessary supporting documentation.

E. The lead agency shall submit a written request for appeal on behalf of a community network that wishes to appeal its performance profile.

F. The department shall review all timely submitted appeal requests and make a recommendation to BESE during the first regularly scheduled BESE meeting following receipt of the appeal request, or during the second regularly scheduled BESE meeting if the appeal request is received within ten working days of the first regularly scheduled BESE meeting. Within this interval, the department shall notify the publicly-funded site or community network of its recommendation and allow the site or community network to respond in writing. The department's recommendation and the site or community network's response shall be submitted to BESE for final disposition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§523. Disaster Consideration for Programs and Community Networks

A. A severe impact site meets either of the following conditions associated with disasters:

1. the site was closed, due to the disaster, for 18 or more consecutive school days during a given school year; or
2. the site gained or lost 25 percent or more of its population due to the disaster.

B. A severe impact community network is a community network that consists of 25 percent or more severe impact sites.

C. Severe impact sites and severe impact community networks qualify for a waiver for up to one school year from participation in the accountability system.

1. BESE shall not issue a performance profile for any severe impact site or severe impact community network for the school year in which the disaster occurred unless the site or community network requests that the performance profile be issued.

2. BESE shall not include severe impact site accountability system results in the performance profile for a community network that does not meet the severe impact criteria but has severe impact sites.

D. Community network lead agencies and sites may address situations not part of the severe impact disaster process through the waiver process for accountability system requirements set forth in §519.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 7. Coordinated Enrollment

§701. Age Cohorts

A. Children shall be placed in a single age cohort for counting purposes in a school year. Each child shall be placed in the appropriate age cohort at the beginning of the

school year and shall remain in that age cohort for the entire school year.

B. A child's age cohort shall be determined by the child's age on September 30 of the school year.

C. Children shall be placed in age cohorts for a school year as follows:

1. four-year-olds are children who have reached or will reach their fourth birthday on or before September 30;
2. three-year-olds are children who have reached or will reach their third birthday on or before September 30;
3. two-year-olds are children who have reached or will reach their second birthday on or before September 30;
4. one-year-olds are children who have reached or will reach their first birthday on or before September 30; and
5. children ages birth to one year are children who have not reached and will not reach their first birthday by or before September 30.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407.91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§703. Coordinated Enrollment Process

A. Coordinated enrollment is the process developed and implemented by a community network to coordinate enrollment for infant, toddler, and PreK children in the community network whose families want to enroll them in a publicly-funded program in the community network.

B. The coordinated enrollment process consists of:

1. a coordinated information campaign through which the community network informs families about the availability of publicly-funded programs serving children ages birth to five years;
2. a coordinated eligibility determination through which the community network coordinates enrollment, eligibility criteria, and waiting lists to ensure that families are referred to other available publicly-funded early childhood programs should they be ineligible for or unable to access their primary choice;
3. a coordinated application process through which the community network conducts a unified application process so families can easily indicate their enrollment choices for publicly-funded programs; and
4. a matching based on family preference through which the community network enrolls at-risk children, using available public funds and based upon stated family preferences.

C. In collaboration with representatives of providers of child care, Head Start, and prekindergarten services, the lead agency shall develop policies and procedures for how the requirements of §703.B will be implemented. These policies and procedures shall be submitted to the department prior to initiation of the enrollment process.

D. Each community network shall operate a coordinated enrollment process for each school year, subject to the implementation timeline provided in §705.

E. The lead agency shall ensure the community network develops and implements a process to enroll publicly-funded children on an ongoing basis outside of the community network's established application period each year.

F. Any publicly-funded program that seeks to enroll children outside of their community network's coordinated enrollment process shall obtain prior written approval from the department.

G. Request for Departmental Review

1. Any parent or caregiver may request that the department review the placement of his or her child resulting from the coordinated enrollment process.

2. A request for departmental review shall be submitted in writing to the department within 15 calendar days of placement of the child or of the event upon which the request for review is based.

3. All requests for departmental review shall clearly state the specific reasons for requesting the review and the action being sought, and shall include all necessary supporting documentation.

4. The department shall respond to the request for departmental review within 30 calendar days after receiving it.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§705. Implementation Timeline

A. Community networks that began receiving funding prior to January 2015 shall develop and implement all four components of the coordinated enrollment process as defined in §703 during the 2015-2016 school year for use in enrollment that begins with the 2016-2017 school year.

B. Community networks that began receiving funding on or after January 2015 shall develop and implement all four components of the coordinated enrollment process as defined in §703 during the 2015-2016 and 2016-2017 school years for use in enrollment that begins with the 2017-2018 school year.

1. Community networks shall establish the coordinated information campaign, coordinated eligibility determination and coordinated application process as defined in §703.B.1-B.3 during the 2015-2016 school year for enrollment that begins with the 2016-2017 school year.

C. The state superintendent, pursuant to authority delegated by BESE, may grant a community network a one year extension of time to develop and implement the enrollment process.

1. Any community network that began receiving funding prior to January 2015 requesting an extension of time shall submit a written request to the department no later than December 1, 2015.

2. Any community network that began receiving funding on or after January 2015 requesting an extension of time shall submit a written request to the department no later than February 1, 2016.

3. The request shall include written justification of the need for the extension and an assurance that families will be informed of the enrollment process for all publicly-funded programs in the community network.

4. The state superintendent, or designee, shall respond in writing to a request within 30 calendar days of receipt of the request.

D. Community networks shall determine preliminary eligibility for families interested in CCAP during the coordinated eligibility determination as provided in §703.B.2 and the department shall determine final eligibility for CCAP.

E. Prior to the start of the 2016-2017 school year, BESE shall review this Chapter and revise as necessary based on learnings from the 2015-2016 learning year. A work group of

the Early Childhood Care and Education Advisory Council shall be formed to study the effectiveness of the coordinated enrollment process conducted in the learning year and make recommendations to the council and BESE for changes for implementation in 2016-2017. This research should include, but not be limited to, conducting focus groups of all provider types, reviewing data on the placement of new early childhood seats opened statewide, and reviewing other available information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§707. Demonstrated Progress toward Implementation

A. No later than August 31, 2015, each community network shall submit a self-assessment of its progress toward full implementation of each component of the coordinated enrollment process as defined in §703.B.

B. The department may require community networks to complete an enrollment self-assessment each year.

C. The lead agency of any community network not making progress on coordinated enrollment, or not achieving the full coordinated enrollment process according to the timeline in §705, may be subject to BESE intervention, as specified in §711.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§709. Community Network Request for Funding for Publicly-Funded Programs

A. By March 31 of each fiscal year, the lead agency shall develop, in collaboration with representatives of providers of child care, Head Start, and prekindergarten services, and submit a funding request for the following fiscal year to the department on behalf of the community network that is based on the coordinated enrollment results, which shall include the following:

1. the number of applications received for each age of at-risk children;

2. the number of seats requested at each publicly-funded site;

3. the number of seats recommended by the lead agency to receive funding with a prioritization by site and age of children served by funding source;

4. the recommended plan to maximize all funding sources to increase service to at-risk children; and

5. the number of seats being requested in a mixed delivery setting.

B. The lead agency shall provide an opportunity for each publicly-funded program in the community network and the general public in the coverage area of the community network to comment on the proposed funding request prior to submission to the department and shall include documentation of this process in the funding request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§711. Local Enrollment Coordinator

A. If the lead agency is not satisfactorily coordinating the duties and responsibilities of the community network pertaining to the community network's coordinated

enrollment process, the department shall send written notification to the lead agency and all programs within the community network. The written notification shall identify the unsatisfactory performance issues and specify any corrective actions that may be required of the lead agency.

B. Within 30 calendar days of receiving such notice, the lead agency shall submit written certification to the department that corrective actions have been taken or are in the process of being taken and submit a timely implementation schedule for the department's approval.

C. If the lead agency does not respond in a timely or satisfactory manner or adhere to the implementation schedule approved by the department, the department may recommend that BESE terminate the lead agency's duties and responsibilities pertaining to coordinated enrollment and authorize a local enrollment coordinator for the community network.

D. A local enrollment coordinator is an entity authorized by BESE to assume responsibility for the services a lead agency is required to provide in coordinating the community network's coordinated enrollment process, as set forth in §309.B.1.b and §§703-709.

1. A local enrollment coordinator may be a state agency, including the department, a public school system, a nonprofit or for-profit corporation having an educational or social services mission, including but not limited to a nonprofit corporation of a philanthropic or policy nature, a Louisiana postsecondary education institution, or a nonprofit corporation established by the governing authority of a parish or municipality.

2. A local enrollment coordinator shall be authorized for a term no greater than five years.

3. A local enrollment coordinator authorized by BESE shall enter into a local enrollment coordinator agreement with the department.

4. If a local enrollment coordinator is authorized, the lead agency's allocation shall be reduced by, or the lead agency shall repay, an amount equal to that portion of the coordinated enrollment duties and responsibilities that remain outstanding.

E. If BESE terminates a lead agency's responsibilities pertaining to coordinated enrollment, but does not terminate the lead agency's approval to serve as the lead agency for the community network, the lead agency shall continue to serve as lead agency and coordinate all other duties and responsibilities of the community network.

F. Funding

1. For each local enrollment coordinator authorized by BESE, the department shall allocate not more than one percent of the public funds appropriated for each publicly-funded program in the community network to support the local enrollment coordinator.

2. The amount allocated from the funding for each publicly-funded site shall be proportionate to the number of publicly-funded children in the site enrolled by the local enrollment coordinator.

3. If an allocation cannot be made from a funding source to support the local enrollment coordinator, the amount established for that funding source to support the local enrollment coordinator shall be allocated from the

remaining public funding sources in an amount proportionate to the number of children in each publicly-funded program enrolled by the local enrollment coordinator.

4. BESE shall not allocate additional funds to support local enrollment coordinators from any public funding source that has a per-child allocation or subsidy below the Louisiana average per-child allocation or subsidy for all programs included in the enrollment system.

G. Audit

1. A local enrollment coordinator shall annually submit to the department an independent financial audit conducted by a certified public accountant who has been approved by the legislative auditor. Such audit shall be accompanied by the auditor's statement that the report is free of material misstatements. The audit shall be limited in scope to those records necessary to ensure that the local enrollment coordinator has used funds to perform required services, and it shall be submitted to the legislative auditor for review and investigation of any irregularities or audit findings.

2. The local early learning enrollment coordinator shall return to the state any funds that the legislative auditor determines were expended in a manner inconsistent with Louisiana law or BESE regulations.

3. The cost of such audit shall be paid by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§713. Request for Departmental Review

A. Any publicly-funded program may request that the department review an enrollment decision or funding request of its lead agency or local enrollment coordinator.

B. A request for departmental review shall be submitted in writing to the department no later than 10 calendar days after the day on which community networks must submit funding requests to the department or the day in which the community network submitted the funding request to the department, whichever is later.

C. All requests for departmental review shall clearly state the specific reasons for requesting the review and the action being sought, and shall include necessary supporting documentation.

D. The department shall respond to the request for review within 30 calendar days after receiving the request or prior to BESE considering funding allocations, whichever is sooner.

E. No publicly-funded program or community network may request departmental review of the funding allocation approved by BESE.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Charles E. "Chas" Roemer, IV
President

1509#032

DECLARATION OF EMERGENCY

Student Financial Assistance Commission Office of Student Financial Assistance

Scholarship/Grant Programs
Acts of the 2015 Regular Session
(LAC 28:IV.705, 803 and 805)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend and re-promulgate the rules of the scholarship/grant programs [R.S. 17:3021-3025, R.S. 3041.10-3041.15, and R.S. 17:3042.1.1-3042.8, R.S. 17:3048.1, and R.S. 56:797.D(2)].

This rulemaking amends the administrative rules to provide that students will have until the end of the academic year to achieve the cumulative grade point average required by their award.

It also provides that high school graduates through the 2016-2017 academic year may utilize the core curriculum that was in effect prior to the passage of Act 403 during the 2015 Regular Session of the Louisiana Legislature.

The Emergency Rule is necessary to implement changes to the scholarship/grant programs to allow the Louisiana Office of Student Financial Assistance and state educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. LASFAC has determined that this Emergency Rule is necessary in order to prevent imminent financial peril to the welfare of the affected students.

This Declaration of Emergency is effective August 20, 2015, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act. (SG16165E)

Title 28 EDUCATION

Part IV. Student Financial Assistance—Higher Education

Scholarship and Grant Programs

Chapter 7. Taylor Opportunity Program for Students (TOPS) Opportunity, Performance, and Honors Awards

§705. Maintaining Eligibility

A. - A.7. ...

8.a. through the 2013-14 academic year (TOPS), maintain at an eligible college or university, by the end of the spring semester, quarter, or term, a TOPS cumulative college grade point average on a 4.00 maximum scale of at least:

i. a 2.30 with the completion of 24 but less than 48 credit hours, a 2.50 after the completion of 48 credit hours, for continuing receipt of an Opportunity Award, if enrolled in an academic program; or

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

b. beginning with the 2014-15 academic year (TOPS), maintain at an eligible college or university, by the end of the academic year, a TOPS cumulative college grade point average on a 4.00 maximum scale of at least:

i. a 2.30 with the completion of 24 but less than 48 credit hours, a 2.50 after the completion of 48 credit hours, for continuing receipt of an Opportunity Award, if enrolled in an academic program; or

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

c. the provisions of §705.A.8.b shall not apply during the 2014-2015 academic year to students who met the requirements of §705.A.7 at the end of the spring semester of 2015, but who did not meet the requirements of §705.A.8.b at the end of the 2014-2015 academic year;

d. beginning with the 2015-16 academic year (TOPS), maintain at an eligible college or university, by the end of the academic year, a TOPS cumulative college grade point average (Opportunity, Performance, Honors) on a 4.00 maximum scale of at least:

i. a 2.30 with 24 but less than 48 earned credit hours for continuing receipt of an Opportunity Award, if enrolled in an academic program for the last semester attended during the academic year; or

ii. a 2.50 with 24 but less than 48 earned credit hours for continuing receipt of an Opportunity Award, if enrolled in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree for the last semester attended during the academic year; or

iii. a 2.50 with 48 or more earned credit hours for continuing receipt of an Opportunity Award, if enrolled in any program of study for the last semester attended during the academic year; and

e. a 3.00 for continuing receipt of either a Performance or Honors Award; or

f. the minimum grade necessary to maintain good standing, if enrolled in a graduate or professional program; or

g. meet the federal grant aid steady academic progress requirement at that school, if enrolled in an eligible cosmetology or proprietary school; and

B.1. Students failing to meet the requirements listed in §705.A.7 or §705.A.8.a, b, d, f, or g may have their tuition awards reinstated upon regaining “steady academic progress” (see §301) and/or attainment of the required TOPS cumulative grade point average, if the period of ineligibility did not persist for more than two years from the date of loss of eligibility.

2. If the two-year period is interrupted due to a student's active duty in the United States Armed Forces, the two-year period will be extended for a length of time equal to the student's active duty service.

3. Students who fail to meet the requirements of §705.A.8.e, shall no longer be eligible for the stipend authorized for the Performance and Honors Awards, but shall be eligible to receive the award amount for the

Opportunity Award if they meet the continuation requirements of §705.A.8.a, b, d, f, or g.

4.a. A student shall have one semester or quarter after the 2015-16 academic year (TOPS) for which the TOPS Award will be paid to meet the requirements of §705.A.8.d if the student:

i. failed to meet the requirements listed in §705.A.8.d solely because the calculation of the TOPS cumulative grade point average (Opportunity, Performance, Honors) at the end of the 2015- 2016 academic year (TOPS) includes both hours and grades for courses taken before the 2015-16 academic year (TOPS) in both academic and technical courses of study; and

ii. was a high school graduate or home study completer who enrolled for the first time as a full time student in an eligible postsecondary institution before the 2015-16 academic year (TOPS); and

iii. not suspended after the 2014-15 academic year (TOPS).

b. The TOPS award of a student who meets the requirements of §705.B.4.a shall not be suspended unless the student fails to meet the requirements of §705.A.8.d by the end of the fall semester or quarter of 2016 in which case:

i. the student's TOPS award shall be suspended effective at the end of the fall semester or quarter of 2016; and

ii. the provisions of §705.B.1 and 2 shall apply.

c. If a student does not enroll full-time for the fall semester or quarter of 2016 and any subsequent consecutive semesters or quarters and is granted an exception for all of those semesters or quarters, the provisions of §705.B.4.b shall be extended to the end of the next semester or quarter during which the student enrolls full time and for which the student's TOPS award is paid.

C. - F.2. ...

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

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:637 (April 1998), amended LR 24:1904 (October 1998), LR 25:257 (February 1999), LR 25:656 (April 1999), LR 25:1091 (June 1999), LR 26:67 (January 2000), LR 26:688 (April 2000), LR 26:1996 (September 2000), LR 26:2001 (September 2000), repromulgated LR 27:1853 (November 2001), amended LR 28:447 (March 2002), LR 28:772 (April 2002), LR 28:2332 (November 2002), LR 29:2373 (November 2003), LR 30:781 (April 2004), LR 30:1163 (June 2004), LR 30:2019 (September 2004), LR 31:3115 (December 2005), LR 33:437 (March 2007), LR 34:1390 (July 2008), LR 36:491 (March 2010), LR 36:2856 (December 2010), LR 38:3159 (December 2012), LR 40:1002 (May 2014), LR 41:664 (April 2015), LR 41:

Chapter 8. TOPS-Tech Award

§803. Establishing Eligibility

A. - A.6.a.iv. ...

v. for students graduating in the 2013-2014 school year through the 2016-2017 school year, the high school course work documented on the student's official transcript as approved by the Louisiana Department of Education constituting the following TOPS-Tech core curriculum;

Core Curriculum—TOPS-Tech Award	
Units	Course
1	English I
1	English II
1	English III
1	English IV or substitute 1 unit of Business English
1	Algebra I; or both Algebra I, Part 1 and Algebra I, Part 2; or both Applied Mathematics I and Applied Mathematics II
2	Geometry, Applied Mathematics III, Algebra II, Financial Mathematics, Advanced Mathematics I [beginning with the 2008-2009 academic year (high school) this course is renamed Advanced Math – Pre-Calculus], Advanced Mathematics II [beginning with the 2008-2009 academic year (high school) this course is renamed Advanced Math – Functions and Statistics], Discrete Mathematics, or Probability and Statistics (2 units). Integrated Mathematics I, II, and III may be substituted for Algebra I, Geometry and Algebra II, and shall be considered the equivalent of the 3 required math units
1	Biology
2	Earth Science, Environmental Science, Physical Science, Integrated Science, Biology II, or Chemistry or Applied Chemistry, Chemistry II, Physics, Physics II or Physics for Technology or Agriscience I and II (both for 1 unit)
1	American History
1	World History, Western Civilization or World Geography
1	Civics and Free Enterprise (1 unit combined) or Civics (1 unit, non-public)
Remaining Core Courses Shall Be Selected from One of the Following Options	
Option 1—Total of 17 Units	
1	Fine Arts Survey or drafting (one unit) or substitute 2 units of performance courses in music, dance, or theater; or substitute 2 units of visual art courses; or substitute 2 units of studio art courses; or a course from the Career and Technical Program of studies that is approved by the BESE (must be listed under the Vocational Education Course Offerings in Bulletin 741 or the updates to Bulletin 741); or substitute 1 unit as an elective from among the other subjects listed in this core curriculum
2	Foreign Language, Technical Writing, Speech I or Speech II
1	One unit from the secondary computer education program of studies that is approved by the BESE
or	
Option 2—Total of 19 Units	
4	In a career major comprised of a sequence of related specialty courses. In order for a student to use this option, the courses for the career major must be approved by BESE.
1	Credit in a basic computer course
1	In related or technical fields. A related course includes any course which is listed under the student's major. A technical course is one that is listed in the approved career option plan for the high school at which the course is taken.

A.6.b. - B.4.b.ii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3025, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:1904 (October 1998), amended LR 24:2237 (December 1998), LR 25:1795 (October 1999), LR 26:65 and 67 (January 2000), LR 26:1602 (August 2000), LR 26:1997 (September 2000), LR 26:2269 (October 2000), LR 26:2754 (December 2000), LR 27:36 (January 2001), LR 27:1220 (August 2001), repromulgated LR 27:1854 (November 2001), amended LR 28:447 (March 2002), LR 28:773 (April 2002), LR 28:2330 (November 2002), LR 29:554 (April 2003), LR 30:1164 (June 2004), LR 30:2019 (September 2004), LR 31:39 (January 2005), LR 31:3114 (December 2005), LR 33:437 (March 2007), LR 33:2614 (December 2007), LR 35:230 (February 2009), LR 36:491 (March 2010), LR 36:2270

(October 2010), LR 36:2856 (December 2010), LR 38:3159 (December 2012), LR 41:654 (April 2015), LR 41:

§805. Maintaining Eligibility

A. - A.6. ...

7.a. through the 2013-14 academic year, maintain, by the end of the spring term, a TOPS cumulative college grade point average (TOPS Tech) of at least 2.50 on a 4.00 maximum scale, provided that this requirement does not apply to a student who is enrolled in a cosmetology or proprietary school that is an eligible college or university and the student has met the federal grant aid steady academic progress requirement at that school; and

b. beginning with the 2014-15 academic year, maintain, by the end of the academic year, a TOPS cumulative college grade point average (TOPS Tech) of at least 2.50 on a 4.00 maximum scale, provided that this requirement does not apply to a student who is enrolled in a cosmetology or proprietary school that is an eligible college or university and the student has met the federal grant aid steady academic progress requirement at that school; and

A.8. - E. ...

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

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:1905 (October 1998) amended LR 25:1091 (June 1999), LR 26:68 (January 2000), LR 26:689 (April 2000), LR 26:1997, 2002 (September 2000), repromulgated LR 27:1856 (November 2001), amended LR 28:774 (April 2002), LR 28:2332 (November 2002), LR 29:880 (June 2003), LR 29:2373 (November 2003), LR 30:781 (April 2004), LR 30:1165 (June 2004), LR 30:2019 (September 2004), LR 31:3115 (December 2005), LR 33:438 (March 2007), LR 35:1489 (August 2009), LR 38:3160 (December 2012), LR 40:1002 (May 2014), LR 41:666 (April 2015), LR 41:

Robyn Rhea Lively
Senior Attorney

1509#007

DECLARATION OF EMERGENCY

**Office of the Governor
Commission on Law Enforcement**

Peace Officer Training (LAC 22:III.4761)

In accordance with the provision of R.S. 40:2401 et seq., the Peace Officer Standards and Training Act, and R.S. 40:905 et seq., which is the Administrative Procedure Act, the Peace Officer Standards and Training Council, under the authority of Act 152 of 2015, provides for the implementation of sexual assault awareness training relative to college and university peace officers.

This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

**Title 22
CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT**

**Part III. Commission on Law Enforcement and
Administration of Criminal Justice**

Subpart 4. Peace Officers

Chapter 47. Standards and Training

§4761. Advanced Training

A. Sexual Assault Awareness Training

1. On and after January 1, 2016, each full-time college or university peace officer shall complete a sexual assault awareness training program as provided by the council pursuant to R.S. 40:2405.8. The training program shall be implemented through a series of learning modules developed for this purpose.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, LR 41:

Public Comments

Interested persons may submit written comments on this Emergency Rule no later than October 20, 2015 at 5 p.m. to Bob Wertz, Louisiana Commission on Law Enforcement, P.O. Box 3133, Baton Rouge, LA 70821.

Joey Watson
Executive Director

1509#046

DECLARATION OF EMERGENCY

**Office of the Governor
Division of Administration
Office of Technology Services**

Procedure for IT Contracts for Consulting Services
(LAC 34:I.Chapter 55)

The Office of the Governor, Division of Administration, Office of Technology Services, enacts LAC 34:I.5521, LAC 34:I.5523, and LAC 34:I.5525 for the procurement of information technology (IT) consulting services, IT systems, IT services, IT equipment or similar services contracts as authorized by R.S. 39:200(L). This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be effective on August 17, 2015 and shall remain in effect for a period of 120 days or until adoption of the Rule, whichever occurs first.

The Office of the Governor, Division of Administration, Office of Technology Services enacts an Emergency Rule in order to adopt provisions which will allow the Office of Technology Services the ability to make multiple awards in Information Technology consulting services contracts (*Louisiana Register*, Volume 41, Number 9).

The Office of Technology Services (OTS) proposes to enact this provision to give it the ability to make multiple

awards from a single request for proposals. This action is being taken via Emergency Rule in order to enable the IT Strategic Sourcing Services request for proposal and other similar OTS solicitations to be posted in a timely manner and prevent a slowdown in providing IT services to the various state agencies. A slowdown in providing IT services could affect OTS' ability to effectuate OTS' statutory obligation to establish and coordinate all information technology services affecting the management and operations of the executive branch of state government. OTS has the sole authority and responsibility for defining and implementing the specific information technology systems and services, defining a state master information technology plan, and creating and managing information technology standards. The creation of OTS consolidates a wide variety of existing hardware platforms, operating systems, database management systems, networks, third party software, and custom applications. These legacy environments currently reside in multiple physical locations, and have been developed over many years under the direction of the each user agencies. OTS plans to apply the Information Technology Infrastructure Library/Control Objectives for Information Technology (ITIL/COBIT) process model to the task of organizing and consolidating the many separate environments; and of identifying and implementing process improvements designed to move the State to more efficient, streamlined, and cost-effective IT operations. Because there is a growing need for a flexible means of obtaining IT services quickly, efficiently, and cost effectively, the Strategic Sourcing Services RFP will be used to identify and award contracts to multiple potential contractors who will be able to provide IT services to user agencies as quickly and efficiently as possible.

It is estimated that implementation of this Emergency Rule will have no fiscal impact to the Division of Administrations' budget for state fiscal year 2015-2016.

Effective August 17, 2015, the Division of Administration, Office of Technology Services enacts provisions allowing the award of multiple contracts for consulting services.

Title 34

GOVERNMENT CONTRACTS, PROCUREMENT AND PROPERTY CONTROL

Part I. Purchasing

Subpart 3. Equipment-Lease-Purchase Program

Chapter 55. Procedures for Information Technology Hardware, Software, Software Maintenance and Support Services and Hardware Maintenance

§5521. Procurement of Information Technology Consulting Services, Information Consulting Systems, Information Technology Services, Information Technology Equipment Using Multiple Awards

A. A multiple award is an award of an indefinite quantity contract for one or more information technology (IT) consulting services, IT systems, IT services, IT equipment or similar service to more than one contractor through the request for proposals or invitation to bid process. A multiple award may be in the state's best interest when award to two or more contractors is needed for adequate delivery, service, or availability. In making a multiple award, care shall be exercised to protect and promote the principles of

competitive solicitation. Multiple awards shall not be made when a single award will meet the state's needs without sacrifice of economy or service. Awards shall not be made for the purpose of dividing the business or avoiding the resolution of tie proposals. Any such awards shall be limited to the least number of IT consultants, IT systems, IT services, or IT equipment necessary to meet the valid requirements of the Office of Technology Services. It shall be mandatory that the requirements of the Office of Technology Services that can be met under the contract be obtained in accordance with the contract, provided, that:

1. the state shall reserve the right to take solicitations separately if a particular service requirement arises which exceeds the scope specified in the contract;

2. the state shall reserve the right to take solicitations separately if the contract will not meet a nonrecurring or special need of the state;

3. the state reserves the right to use its own personnel to provide similar services when such services are available and satisfy the Office of Technology Services need.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:200(L).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Technology Services, LR 41:

§5523. Intent to Use

A. If a multiple award is anticipated prior to issuing a solicitation, the method of award should be stated in the solicitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:200(L).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Technology Services, LR 41:

§5525. Determination Required

A. The chief information officer shall make a written determination setting forth the reasons for a multiple award, which shall be made a part of the procurement file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:200(L).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Technology Services, LR 41:

Richard Howze
Chief Information Officer

1509#003

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Inpatient Psychiatric Services
Reimbursement Rate Reduction
(LAC 50:V.959 and 2709)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.959 and §2709 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S.

49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services amended the provisions governing the reimbursement methodology for inpatient hospital services in order to provide supplemental Medicaid payments to non-rural, non-state acute care hospitals that enter into a cooperative endeavor agreement with the department to provide inpatient psychiatric services (*Louisiana Register*, Volume 39, Number 2). The department amended the provisions governing disproportionate share hospital (DSH) payments to non-state distinct part psychiatric units that enter into a cooperative endeavor agreement with the department's Office of Behavioral Health (*Louisiana Register*, Volume 39, Number 3).

As a result of a budgetary shortfall in state fiscal year 2016, the department has determined that it is necessary to amend the provisions governing DSH payments to reduce the payments made to non-rural, non-state acute care hospitals for inpatient psychiatric services.

This action is being taken to avoid a budget deficit in the Medical Assistance Program. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$307,425 for state fiscal year 2015-2016.

Effective October 1, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing disproportionate share hospital payments to reduce the payments made to non-rural, non-state acute care hospitals for inpatient psychiatric services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§959. Inpatient Psychiatric Hospital Services

A. - L. ...

M. Effective for dates of service on or after October 1, 2015, the prospective per diem rate paid to non-rural, non-state acute care hospitals that enter into a CEA with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to uninsured patients, shall be reduced by 5 percent of the per diem rate on file as of September 30, 2015. The new per diem rate shall be \$552.05 per day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 39:94 (January 2013), LR 39:323 (February 2013), LR 41:

Subpart 3. Disproportionate Share Hospital Payments

Chapter 27. Qualifying Hospitals

§2709. Distinct Part Psychiatric Units

A. - C. ...

D. Effective for dates of service on or after October 1, 2015, the prospective per diem rate paid to non-rural, non-state acute care hospitals that enter into a CEA with the

Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to uninsured patients, shall be reduced by 5 percent of the per diem rate on file as of September 30, 2015 for distinct part psychiatric unit services. The new per diem rate shall be \$552.05 per day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1627 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:505 (March 2013), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to Medicaid.Policy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#062

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Facility Need Review
(LAC 48:I.Chapter 125)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.Chapter 125 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2116. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the facility need review (FNR) process to adopt provisions governing the inclusion of outpatient abortion facilities in the FNR Program (*Louisiana Register*, Volume 38, Number 8). The department promulgated an Emergency Rule which amended the provisions governing the FNR Program in order to revise the definition for *home and community-based service providers* to include monitored in-home caregiving (MIHC) services, and to revise the provisions governing the service area for adult day health care providers (*Louisiana Register*, Volume 40, Number 11). The department now proposes to amend the provisions of the November 20, 2014 Emergency Rule to: 1) Clarify the definition of *adult residential care* providers; 2) provide a process for supplementing an FNR application that has been

denied prior to appeal; 3) provide time frames within which certain providers must become licensed after they have been approved through the FNR process; and 4) amend the provisions governing the FNR process for nursing facilities relative to the statutory moratorium.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation in the FNR Program.

Effective September 20, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the November 20, 2014 Emergency Rule governing the Facility Need Review Program in order to revise and clarify these provisions.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 5. Health Planning

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. ...

* * *

Adult Residential Care Provider (ARCP)—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group, which provides adult residential care services for compensation to two or more adults who are unrelated to the licensee or operator. Adult residential care includes, but is not limited to the following services: lodging, meals, medication administration, intermittent nursing services, and assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping and laundry. For the purposes of this FNR Rule, ARCP refers to an entity that is or will be licensed as an “ARCP Level 4 – Adult Residential Care Provider”.

* * *

Home and Community Based Service (HCBS) Providers—those agencies, institutions, societies, corporations, facilities, person or persons, or any other group intending to provide or providing respite care services, personal care attendant (PCA) services, supervised independent living (SIL) services, monitored in-home caregiving (MIHC) services, or any combination of services thereof, including respite providers, SIL providers, MIHC providers, and PCA providers.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:135 (January 2015), LR 41:

§12505. Application and Review Process

A. - B.3.b. ...

4. If FNR approval is denied, the applicant may choose to:

a. pursue an Administrative Appeal pursuant to Subchapter G §12541; or,

b. within 30 days of receipt of the notice of denial of FNR approval, and prior to filing an Administrative Appeal, request a supplemental review of additional documentation to be submitted by the applicant.

i. The time period to submit the supplemental materials shall be no later than 30 days from the date the request is approved by the department and notice received by the applicant. If timely received, the supplemental documentation will be reviewed in conjunction with the original FNR application. The applicant will receive the results of such review in writing from the department.

ii. In the case of a failure to submit the supplemental materials in a timely manner or, upon a denial of the supplemental application, the applicant may file an administrative appeal of the department’s decision with the Division of Administrative Law (DAL). This request shall be submitted within 30 days of the date of receipt of notice of said failure or denial.

iii. Failure to file timely for an administrative appeal shall exhaust the applicant’s remedies with the department and the decision to deny FNR approval is final.

c. The administrative appeal shall be conducted by the DAL in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), LR 35:2438 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 41:

§12508. Pediatric Day Health Care Providers

A. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. PDHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. PDHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:136 (January 2015), amended LR 41:

§12511. Nursing Facilities

A. - J.4.a. ...

NOTE: Pursuant to LA R.S. 40:2116(D)(2), the Department of Health and Hospitals shall not approve any additional nursing facilities or additional beds in nursing facilities through facility need review. This prohibition shall apply to additional licensed beds as well as Medicaid certified beds. This prohibition shall not apply to the replacement of existing facilities, provided that there is no increase in existing nursing home beds at the replacement facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2615 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3264 (November 2011), LR 41:

§12523. Home and Community-Based Service Providers

A. - E.3. ...

F. FNR approved HCBS applicants shall become licensed no later than six months from the date of the FNR approval.

1. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant. Inappropriate zoning is not a basis for extension.

2. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the HCBS agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2438 (November 2009), amended LR 41:

Subchapter B. Determination of Bed, Unit, Facility, or Agency Need

§12525. Adult Day Health Care Providers

A. ...

B. For purposes of facility need review, the service area for a proposed ADHC provider shall be within a 30 mile radius of the proposed physical address where the provider will be licensed.

C. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. ADHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. ADHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the ADHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:323 (February 2010), amended LR 41:

§12526. Hospice Providers

A. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and/or licensure.

1. Outpatient Hospice agencies shall be licensed within 6 months from the date of the FNR approval.

2. Inpatient Hospice facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

3. Inpatient Hospice facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

4. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

5. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the Hospice agency or facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1593 (July 2012), amended LR 41:

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#063

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing
and**

Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
New Opportunities Waiver
Emergency Opportunities
(LAC 50: XXI.13709)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities amend LAC 50:XXI.13709 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities amended the provisions governing the New Opportunities Waiver (NOW) in order to clarify the provisions of the waiver and to add the following new services to the waiver program: 1) housing stabilization transition; 2) housing stabilization; 3) remote assistance; and 4) adult companion care (*Louisiana Register*, Volume 40, Number 1).

The department has now determined that it is necessary to amend the provisions governing the allocation of waiver opportunities in the NOW to revise the criteria for emergency waiver services, simplify the allocation process for NOW emergency opportunities, and facilitate faster access to NOW emergency services for qualified individuals. This action is being taken to avoid imminent peril to the health and welfare of NOW participants in crisis situations who are in dire need of waiver services. It is estimated that implementation of this Emergency Rule will have no fiscal impact on expenditures in the Medicaid Program for state fiscal year 2015-2016.

Effective October 1, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the allocation of waiver opportunities for NOW services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXI. Home and Community Based Services

Waivers

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13709. Emergency Opportunities

A. Requests for emergency waiver services shall be made through the local governing entities (LGEs) responsible for coordination of services for persons with developmental disabilities. When a request for emergency services is received, the LGE shall complete a priority assessment that incorporates standardized operational procedures with standardized assessment tools to determine the priority of the individual's need in a fair and consistent manner.

B. To be considered for emergency waiver supports, the individual must need long-term supports, not temporary or short-term supports.

1. - 5. Repealed.

C. Effective for dates of service on or after October 1, 2015, an individual must meet the required criteria based on urgency of need as defined in the screening tool(s) approved by OCDD in order to qualify for emergency waiver services.

D. For individuals who meet the criteria for an emergency waiver opportunity, the LGE will forward a copy of the screening tool(s) and all of the additional documents required for processing to the appropriate DHH emergency review manager at OCDD who will verify the applicant's request for services registry date and assign priority. Emergency waiver opportunities will be allocated on a first come, first served basis based on each individual's request

for services registry date. The LGE will keep all of the supporting documentation used to determine whether an applicant has met emergency waiver criteria.

E. A uniform process, designed by OCDD, will be applied in instances when there are more requests than available opportunities for emergency waiver services. This process does not determine eligibility for services and cannot be appealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2901 (November 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#064

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Children's Specialty Hospitals
Supplemental Payments for New Orleans Area Hospitals
(LAC 50:V.969)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.969 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain children's specialty hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which adopted a supplemental payment methodology for inpatient hospital services rendered by children's specialty hospitals in the New Orleans area (*Louisiana Register*, Volume 41, Number 2). This

Emergency Rule is being promulgated to continue the provisions of the February 12, 2015 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing supplemental payments for inpatient hospital services rendered by children's specialty hospitals in the New Orleans area.

**Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE**

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§969. Supplemental Payments to Children's Specialty Hospitals in the New Orleans Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered in a hospital in the New Orleans area that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

1. classified by Medicare as a specialty children's hospital;
2. has a least 100 full-time equivalent interns and residents;
3. has least 70 percent Medicaid inpatient days' utilization rate;
4. has at least 25,000 Medicaid inpatient days; and
5. has a distinct part psychiatric unit.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;
2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and
3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#066

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing**

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Children's Specialty Hospitals Reimbursements
(LAC 50:V.967)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.967 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Due to a budgetary shortfall in SFY 2013, the Department of Health and Hospitals, Bureau of Health Services Financing, amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates paid to non-rural, non-state hospitals, including children's specialty hospitals (*Louisiana Register*, Volume 40, Number 2).

The department subsequently promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services rendered by children's specialty hospitals to revise the reimbursement methodology and establish outlier payment provisions (*Louisiana Register*, Volume 40, Number 10). This Emergency Rule is being promulgated to continue the provisions of the October 4, 2014 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining access to neonatal and pediatric intensive care unit services and encouraging the continued participation of hospitals in the Medicaid Program.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services rendered by children's specialty hospitals.

**Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE**

Part V. Hospital Services

Subpart 1. Inpatient Hospitals

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§967. Children's Specialty Hospitals

A. Routine Pediatric Inpatient Services. For dates of service on or after October 4, 2014, payment shall be made per a prospective per diem rate that is 81.1 percent of the

routine pediatric inpatient cost per day as calculated per the “as filed” fiscal year end cost report ending during SFY 2014. The “as filed” cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Repealed.

B. Inpatient Psychiatric Services. For dates of service on or after October 4, 2014, payment shall be a prospective per diem rate that is 100 percent of the distinct part psychiatric cost per day as calculated per the as filed fiscal year end cost report ending during SFY 2014. The as filed cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Repealed.

C. Carve-Out Specialty Services. These services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants.

1. Transplants. Payment shall be the lesser of costs or the per diem limitation for each type of transplant. The base period per diem limitation amounts shall be calculated using the allowable inpatient cost per day for each type of transplant per the cost reporting period which ended in SFY 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid (CMS) beginning with the cost reporting periods starting on or after January 1, 2010.

a. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid days for the period for each type of transplant multiplied times the per diem limitation for the period.

2. Neonatal Intensive Care Units, Pediatric Intensive Care Units, and Burn Units. For dates of service on or after October 4, 2014, payment for neonatal intensive care units, pediatric intensive care units, and burn units shall be made per prospective per diem rates that are 84.5 percent of the cost per day for each service as calculated per the “as filed” fiscal year end cost report ending during SFY 2014. The “as filed” cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

D. Children’s specialty hospitals shall be eligible for outlier payments for dates of service on or after October 4, 2014.

1. Repealed.

E. ...

1. Repealed.

F. Effective for dates of service on or after February 3, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 5 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 95 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

G. Effective for dates of service on or after August 1, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 4.6 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 90.63 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

H. Effective for dates of service on or after January 1, 2011, the per diem rates as calculated per §967.C.1 above shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 88.82 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

I. - I.3. ...

J. Effective for dates of service on or after August 1, 2012, the per diem rates as calculated per §967.C.1 above shall be reduced by 3.7 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 85.53 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

K. Effective for dates of service on or after February 1, 2013, the per diem rates as calculated per §967.C.1 above shall be reduced by 1 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 84.67 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2562 (November 2010), amended LR 37:2162 (July 2011), LR 38:2773 (November 2012), LR 39:3097 (November 2013), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended LR 40:1941 (October 2014), LR 41:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#067

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Baton Rouge Area Hospitals
(LAC 50:V.973)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.973 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing inpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area (*Louisiana Register*, Volume 41, Number 2). This Emergency Rule is being promulgated to continue the provisions of the February 12, 2015 Emergency Rule.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in the Baton Rouge area.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§973. Supplemental Payments to Baton Rouge Area Hospitals

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered in a hospital in the Baton Rouge area that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

1. classified as a major teaching hospital;
2. has at least 3,000 Medicaid deliveries, as verified per the Medicaid data warehouse; and
3. has at least 45 percent Medicaid inpatient days utilization rate.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;
2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and
3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#068

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Monroe Area Hospitals
(LAC 50:V.971)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.971 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the State Plan Amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals (DHH), Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in DHH Administrative Region 8 in the Monroe area (*Louisiana Register*, Volume 41, Number 2). This Emergency Rule is being promulgated in order to continue the provisions of the February 12, 2015 Emergency Rule.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in the Monroe area.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services
Chapter 9. Non-Rural, Non-State Hospitals
Subchapter B. Reimbursement Methodology
§971. Supplemental Payments to Monroe Area Hospitals

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered by a hospital in the Monroe area that meets the following qualifying criteria:

1. inpatient acute hospital classified as a major teaching hospital;
2. located in DHH Administrative Region 8 (lowest per capita income of any region per the 2010 U.S. Census Bureau records); and
3. per the as filed fiscal year ending June 30, 2013 cost report has:
 - a. greater than 25 full-time equivalent interns and residents;
 - b. at least 40 percent Medicaid inpatient days utilization; and
 - c. a distinct part psychiatric unit.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;
2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and
3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#069

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Public-Private Partnerships
South Louisiana Area
(LAC 50:V.1703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.1703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing inpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services. Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-provider partnership initiative (*Louisiana Register*, Volume 38, Number 11). The department promulgated an Emergency Rule which amended the provisions governing reimbursement for Medicaid payments for inpatient services provided by non-state owned major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated or reduced by a state owned and operated facility (*Louisiana Register*, Volume 39, Number 4). The department subsequently promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient services provided by non-state owned hospitals participating in public-private partnerships to establish payments for hospitals located in the Lafayette and New Orleans areas (*Louisiana Register*, Volume 39, Number 7).

The department promulgated an Emergency Rule which amended the provisions of the June 24, 2013 Emergency Rule governing inpatient hospital services to remove the provisions governing the cooperative endeavor agreements for Lafayette and New Orleans area hospitals as a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the corresponding State Plan Amendments (*Louisiana Register*, Volume 40, Number 6). This Emergency Rule is being promulgated to continue the provisions of the June 20, 2014 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective October 17, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 17. Public-Private Partnerships

§1703. Reimbursement Methodology

A. Reserved.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility shall be reimbursed as follows:

1. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. Baton Rouge Area Cooperative Endeavor Agreement

1. The Department of Health and Hospitals (DHH) shall enter into a cooperative endeavor agreement (CEA) with a non-state owned and operated hospital to increase its provision of inpatient Medicaid hospital services by providing services that were previously delivered and terminated by the state-owned and operated facility in Baton Rouge.

2. A quarterly supplemental payment shall be made to this qualifying hospital for inpatient services based on dates of service on or after April 15, 2013. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

3. The qualifying hospital shall provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient quarterly payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. Before the final quarterly payment for each state fiscal year the quarterly reports will be reviewed and verified with Medicaid claims data. The final quarterly payment for each state fiscal year will be reconciled and will be adjusted to assure that the annual payment does not exceed the allowable Medicaid inpatient charge differential.

4. Inpatient services shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

D. - K. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#070

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing**

Intermediate Care Facilities for
Persons with Intellectual Disabilities
Complex Care Reimbursements (LAC 50:VII.32915)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:VII.32915 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides Medicaid reimbursement to non-state intermediate care facilities for persons with intellectual disabilities (ICFs/ID) for services provided to Medicaid recipients.

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for ICFs/ID to establish reimbursement for complex care services provided to Medicaid recipients residing in non-state ICFs/ID (*Louisiana Register*, Volume 40, Number 10). This Emergency Rule is being promulgated to continue the provisions of the October 1, 2014 Emergency Rule. This action is being taken to protect the public health and welfare of Medicaid recipients with complex care needs who reside in ICFs/ID.

Effective September 29, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing non-state ICFs/ID to establish reimbursement for complex care services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part VII. Long Term Care

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32915. Complex Care Reimbursements

A. Effective for dates of service on or after October 1, 2014, non-state intermediate care facilities for persons with intellectual disabilities may receive an add-on payment to the per diem rate for providing complex care to Medicaid

recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. equipment only;
2. direct service worker(DSW);
3. nursing only;
4. equipment and DSW;
5. DSW and nursing;
6. nursing and equipment; or
7. DSW, nursing, and equipment.

B. Non-state owned ICFs/ID may qualify for an add-on rate for recipients meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the department. All medical documentation indicated by the screening tool form and any additional documentation requested by the department must be provided to qualify for the add-on payment.

C. In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

1. endorsement of at least one qualifying condition with supporting documentation; and
2. endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

a. Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

- i. significant physical and nutritional needs requiring full assistance with nutrition, mobility, and activities of daily living;
- ii. complex medical needs/medically fragile; or
- iii. complex behavioral/mental health needs.

D. Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:

1. endorsement and supporting documentation indicating the need for additional direct service worker resources;
2. endorsement and supporting documentation indicating the need for additional nursing resources; or
3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the recipient has been admitted to the facility for more than 30 days with supporting documentation of necessity and provision of enhanced supports; or
2. the recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.

F. All of the following criteria will apply for continued evaluation and payment for complex care.

1. Recipients receiving enhanced rates will be included in annual surveys to ensure continuation of supports and review of individual outcomes.

2. Fiscal analysis and reporting will be required annually.

3. The provider will be required to report on the following outcomes:

- a. hospital admissions and diagnosis/reasons for admission;
- b. emergency room visits and diagnosis/reasons for admission;
- c. major injuries;
- d. falls; and
- e. behavioral incidents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#071

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Intermediate Care Facilities for Persons with
Intellectual Disabilities—Public Facilities
Reimbursement Rate Increase
(LAC 50:VII.32969)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.32969 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for public intermediate care facilities for persons with developmental disabilities (ICFs/DD), hereafter referred to as intermediate care facilities for persons with intellectual disabilities (ICFs/ID), to establish a transitional Medicaid reimbursement rate for community homes that are being privatized (*Louisiana Register*, Volume 39, Number 2). This Rule also adopted all of the provisions governing reimbursements to state-owned and operated facilities and quasi-public facilities in a codified format for inclusion in the *Louisiana Administrative Code*.

The department promulgated an Emergency Rule which amended the provisions governing the transitional rates for public facilities in order to redefine the period of transition (*Louisiana Register*, Volume 39, Number 10). The department subsequently promulgated an Emergency Rule to assure compliance with the technical requirements of R.S. 49:953, and to continue the provisions of the October 1, 2013 Emergency Rule governing transitional rates for public facilities (*Louisiana Register*, Volume 40, Number 3). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for ICFs/ID to increase the add-on amount to the per diem rate for the provider fee (*Louisiana Register*, Volume 40, Number 3).

Due to an increase in the add-on amount to the per diem rate for the provider fee, the department promulgated an Emergency Rule which amended the provisions governing the transitional rates for public facilities in order to increase the Medicaid reimbursement rate (*Louisiana Register*, Volume 40, Number 9). This Emergency Rule is being promulgated to continue the provisions of the October 1, 2014 Emergency Rule. This action is being taken to protect the public health and welfare of Medicaid recipients transitioning from public ICFs/ID by ensuring continued provider participation in the Medicaid Program.

Effective September 29, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for public intermediate care facilities for persons with intellectual disabilities.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part VII. Long Term Care

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter C. Public Facilities

§32969. Transitional Rates for Public Facilities

A. - F.4. ...

G. Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by \$1.85 of the rate in effect on September 30, 2014.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:326 (February 2013), amended LR 40:2588 (December 2014), LR 41:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#072

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Medicaid Eligibility
Medically Needy Program
Behavioral Health Services
(LAC 50:III.2313)

The Department of Health and Hospitals, Bureau of Health Services Financing hereby repeals and replaces all of the Rules governing the Medically Needy Program, and adopts LAC 50:III.2313 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule in order to reinstate the Title XIX Medically Needy Program (MNP) and to establish coverage restrictions (*Louisiana Register*, Volume 24, Number 5). All Behavioral health services are restricted from coverage under the Medically Needy Program.

In February 2012, the department adopted provisions in the Medicaid Program to restructure the existing behavioral health services delivery system into a comprehensive service delivery model called the Louisiana Behavioral Health Partnership (LBHP). Certain recipients enrolled in the Medically Needy Program, whose Medicaid eligibility is based solely on the provisions of §1915(i) of Title XIX of the Social Security Act, are eligible to only receive behavioral health services. These recipients have difficulties accessing behavioral health services through the LBHP due to the service restrictions currently in place in the Medically Needy Program.

Therefore, the department promulgated an Emergency Rule which revised the provisions governing the Medically Needy Program in order to include behavioral health coverage for MNP recipients that qualify for the program under the provisions of §1915(i) of Title XIX of the Social Security Act. This Emergency Rule also repealed and replaced all of the Rules governing the Medically Needy Program in order to repromulgate these provisions in a clear and concise manner for inclusion in the *Louisiana Administrative Code* in a codified format (*Louisiana Register*, Volume 38, Number 12).

The department promulgated an Emergency Rule which amended the provisions governing the Medically Needy Program to further clarify the provisions governing covered services (*Louisiana Register*, Volume 39, Number 4). The department promulgated an Emergency Rule which amended the provisions of the April 20, 2013 Emergency Rule in order to further clarify these provisions (*Louisiana Register*, Volume 40, Number 1). The department subsequently promulgated an Emergency Rule which amended the

provisions of the January 20, 2014 Emergency Rule in order to further clarify these provisions (*Louisiana Register*, Volume 41, Number 8). The department now proposes to amend the provisions of the August 20, 2015 Emergency Rule in order to further clarify the provisions governing allowable medical expenses for Spend-Down MNP coverage.

This action is being taken to promote the health and welfare of MNP recipients who are in need of behavioral health services, and to assure their continued access to these services.

Effective September 20, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the August 20, 2015 Emergency Rule governing the Medically Needy Program.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2313. Medically Needy Program

A. The Medically Needy Program (MNP) provides Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program, but not sufficient to meet medical needs according to the MNP standards.

1. The income standard used in the MNP is the federal medically needy income eligibility standard (MNIES).

2. Resources are not applicable to Modified Adjusted Gross Income (MAGI) related MNP cases.

3. MNP eligibility cannot be considered prior to establishing income ineligibility in a categorically related assistance group.

B. MNP Eligibility Groups

1. Regular Medically Needy

a. Prior to the implementation of the MAGI income standards, parents who met all of the parent and caretaker relative (PCR) group categorical requirements and whose income was at or below the MNIES were eligible to receive Regular MNP benefits. With the implementation of the MAGI-based methodology for determining income and household composition and the conversion of net income standards to MAGI equivalent income standards, individuals who would have been eligible for the Regular Medically Needy Program are now eligible to receive Medicaid benefits under the parent and caretaker relative eligibility group. Regular Medically Needy coverage is only applicable to individuals included in the MAGI-related category of assistance.

b. Individuals in the non-MAGI (formerly aged (A-), blind (B-), or disability (D-) related assistance groups cannot receive Regular MNP.

c. The certification period for Regular MNP cannot exceed six months.

2. Spend-Down Medically Needy

a. Spend-Down MNP is considered after establishing financial ineligibility in categorically related Medicaid programs and excess income remains. Allowable medical bills/expenses incurred by the income unit, including skilled nursing facility coinsurance expenses, are

used to reduce (spend-down) the income to the allowable MNP limits.

b. The following individuals may be considered for Spend-Down MNP:

i. individuals who meet all of the parent and caretaker relative group requirements;

ii. non-institutionalized individuals (non-MAGI related); and

iii. institutionalized individuals or couples (non-MAGI related) with Medicare co-insurance whose income has been spent down.

c. The certification period for Spend-Down MNP begins no earlier than the spend-down date and shall not exceed three months.

3. Long Term Care (LTC) Spend-Down MNP

a. Individuals residing in Medicaid LTC facilities, not on Medicare-coinsurance with resources within the limits, but whose income exceeds the special income limits (three times the current Federal Benefit Rate), are eligible for LTC Spend-Down MNP.

4. Louisiana Behavioral Health Partnership (LBHP) 1915(i) MNP

a. The LBHP Medically Needy Program is considered only for the individuals who meet the level of need requirements of §1915 of Title XIX of the Social Security Act, and who have been determined to be ineligible for other full Medicaid programs, including the Regular MNP and Spend-Down MNP.

b. LBHP 1915(i) MNP recipients are only eligible to receive behavioral health services through the LBHP. They do not qualify for other Medicaid covered services.

c. The certification period for LBHP 1915(i) Regular MNP recipients cannot exceed six months. For the LBHP 1915(i) Spend-Down MNP, the certification period begins no earlier than the spend-down date and shall not exceed three months.

C. The following services are covered in the Medically Needy Program for non-1915(i) recipients:

1. inpatient and outpatient hospital services;
2. intermediate care facilities for persons with intellectual disabilities (ICF/ID) services;
3. intermediate care and skilled nursing facility (ICF and SNF) services;
4. physician services, including medical/surgical services by a dentist;
5. nurse midwife services;
6. certified registered nurse anesthetist (CRNA) and anesthesiologist services;
7. laboratory and x-ray services;
8. prescription drugs;
9. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
10. rural health clinic services;
11. hemodialysis clinic services;
12. ambulatory surgical center services;
13. prenatal clinic services;
14. federally qualified health center services;
15. family planning services;
16. durable medical equipment;
17. rehabilitation services (physical therapy, occupational therapy, speech therapy);

18. nurse practitioner services;
19. medical transportation services (emergency and non-emergency);
20. home health services for individuals needing skilled nursing services;
21. chiropractic services;
22. optometry services;
23. podiatry services;
24. radiation therapy; and
25. behavioral health services.

D. The following behavioral health services are covered for LBHP 1915(i) MNP recipients:

1. inpatient and outpatient hospital services;
2. emergency medical services;
3. physician/psychiatrist services;
4. treatment by a licensed mental health professional;
5. community psychiatric support and treatment;
6. psychosocial rehabilitation;
7. crisis intervention;
8. case conference [1915(b) services]; and
9. treatment planning [1915(b) services].

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#065

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Children's Specialty Hospitals
Supplemental Payments for
New Orleans Area Hospitals
(LAC 50:V.6121)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6121 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain children's specialty hospitals from state-owned and operated

to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which adopted a supplemental payment methodology for outpatient hospital services rendered by children's specialty hospitals in the New Orleans area (*Louisiana Register*, Volume 41, Number 2). This Emergency Rule is being promulgated to continue the provisions of the February 12, 2015 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing outpatient supplemental payments for outpatient hospital services rendered by children's specialty hospitals in the New Orleans area.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospitals

Subpart 5. Outpatient Hospitals

Chapter 61. Other Outpatient Hospital Services

Subchapter B. Reimbursement Methodology

§6121. Supplemental Payments for Children's Specialty Hospitals in the New Orleans Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered in a hospital in the New Orleans area that meets the following qualifying criteria per the as filed cost report in state fiscal year 2014:

1. classified by Medicare as a specialty children's hospital;
2. has at least 100 full-time equivalent interns and residents;
3. has at least 70 percent Medicaid inpatient days' utilization rate;
4. has at least 25,000 Medicaid inpatient days; and
5. has a distinct part psychiatric unit.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and
2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O.

Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#073

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for
Baton Rouge Area Hospitals
(LAC 50:V.6905)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6905 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area (*Louisiana Register*, Volume 41, Number 2). This Emergency Rule is being promulgated to continue the provisions of the February 12, 2015 Emergency Rule.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to outpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for outpatient hospital services rendered by non-rural, non-state hospitals in the Baton Rouge area.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 69. Supplemental Payments

§6905. Non-Rural, Non-State Hospitals in the Baton Rouge Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for

outpatient hospital services rendered in a hospital in the Baton Rouge area that meets the following qualifying criteria per the as filed cost report ending state fiscal year 2014:

1. classified as a major teaching hospital;
2. has at least 3,000 Medicaid deliveries, as verified per the Medicaid data warehouse; and
3. has at least 45 percent Medicaid inpatient days utilization rate.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and
2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#074

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for
Monroe Area Hospitals
(LAC 50:V.6903)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services'

disapproval of the State Plan Amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in DHH Administrative Region 8 in the Monroe area (*Louisiana Register*, Volume 41, Number 3). This Emergency Rule is being promulgated to continue the provisions of the February 12, 2015 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to outpatient hospital services through the maximization of federal dollars.

Effective October 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing supplemental payments for outpatient hospital services rendered by non-rural, non-state hospitals in the Monroe area.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 69. Supplemental Payments

§6903. Non-Rural, Non-State Hospitals in the Monroe Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered by a hospital in the Monroe area that meets the following qualifying criteria:

1. inpatient acute hospital classified as a major teaching hospital;
2. located in DHH administrative region 8 (lowest per capita income of any region per the 2010 U.S. Census Bureau records); and
3. per the as filed fiscal year ending June 30, 2013 cost report has:
 - a. greater than 25 full-time equivalent interns and residents;
 - b. at least 40 percent Medicaid inpatient days utilization; and
 - c. a distinct part psychiatric unit.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and
2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement methodology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and

Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#075

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Public-Private Partnerships
South Louisiana Area
(LAC 50:V.6703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.6703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing outpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned hospitals that have terminated or reduced services (*Louisiana Register*, Volume 38, Number 11). Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative. The department promulgated an Emergency Rule which amended the provisions of the November 1, 2012 Emergency Rule to revise the reimbursement methodology in order to correct the federal citation (*Louisiana Register*, Volume 39, Number 3). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient services provided by non-state owned major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated or reduced by a state owned and operated facility (*Louisiana Register*, Volume 39, Number 4). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient services provided by non-state owned hospitals participating in public-private partnerships to establish payments for hospitals located in the Lafayette and New Orleans areas (*Louisiana Register*, Volume 39, Number 7).

The department promulgated an Emergency Rule which amended the provisions of the June 24, 2013 Emergency Rule to remove the New Orleans Area hospital which was erroneously included in these provisions (*Louisiana Register*, Volume 39, Number 10). This Emergency Rule is being promulgated to continue the provisions of the October 20, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective October 16, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for outpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 67. Public-Private Partnerships

§6703. Reimbursement Methodology

A. - B.5. Reserved.

C. Baton Rouge Area Cooperative Endeavor Agreement

1. The Department of Health and Hospitals shall enter into a cooperative endeavor agreement with a non-state owned and operated hospital to increase its provision of outpatient Medicaid hospital services by providing services that were previously delivered and terminated by the state-owned and operated facility in Baton Rouge.

2. A quarterly supplemental payment may be made to this qualifying hospital for outpatient services based on dates of service on or after April 15, 2013. Payments may be made quarterly based on the annual upper payment limit calculation per state fiscal year. Maximum payments shall not exceed the upper payment limit per 42 CFR 447.321.

D. Lafayette Area Cooperative Endeavor Agreement

1. The Department of Health and Hospitals shall enter into a cooperative endeavor agreement with a non-state owned and operated hospital to increase its provision of outpatient Medicaid hospital services by assuming the management and operation of services at a facility in Lafayette where such services were previously provided by a state owned and operated facility.

2. Effective for dates of service on or after June 24, 2013, a quarterly supplemental payment may be made to this qualifying hospital for outpatient services. Payments may be made quarterly based on the annual upper payment limit calculation per state fiscal year. Maximum payments shall not exceed the upper payment limit per 42 CFR 447.321.

E. - E.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR: 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to

MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#076

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Pharmacy Benefits Management Program Methods of Payment

The Department of Health and Hospitals, Bureau of Health Services Financing hereby rescinds the provisions of the November 1, 2012 Emergency Rule which revised the reimbursement methodology for pharmacy services covered under the Medical Assistance Program as authorized by R.S. 36:254. This Emergency Rule was adopted on October 19, 2012 and published in the November 20, 2012 edition of the *Louisiana Register*. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage and reimbursement for prescription drugs to Medicaid eligible recipients enrolled in the Medicaid Program. The department promulgated an Emergency Rule which amended the provisions of the September 5, 2012 Emergency Rule to further revise the provisions governing the methods of payment for prescription drugs and the dispensing fee (*Louisiana Register*, Volume 38, Number 11).

Upon further consideration and consultation with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on the corresponding Medicaid State Plan Amendment, the department determined that it was necessary to rescind the provisions of the November 1, 2012 Emergency Rule governing the reimbursement methodology for services rendered in the Pharmacy Benefits Management Program, and to return to the reimbursement rates in effect on September 5, 2012 which is consistent with the currently approved Medicaid State Plan (*Louisiana Register*, Volume 40, Number 10). This Emergency Rule is being promulgated to continue the provisions of the October 1, 2014 Emergency Rule.

Effective September 29, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing rescinds the Emergency Rule governing pharmacy services which appeared in the November 20, 2013 edition of the *Louisiana Register* on pages 2725-2728.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1509#077

DECLARATION OF EMERGENCY

Department of Public Safety and Corrections Office of Motor Vehicles

Compulsory Insurance Enforcement
(LAC 55:III.Chapter 17)

The Office of Motor Vehicles finds that an imminent peril to the public welfare, requires adoption of a Rule upon shorter notice than that provided in R.S. 49:953(A), as provided in R.S. 49:953(B)(1)(a), as uninsured drivers continue to operate motor vehicles, thereby jeopardizing the welfare of law abiding citizens who may be the crash victims of the uninsured drivers, and as the proposed companion permanent Rule cannot be adopted until December 20, 2015 at the earliest, it is necessary to adopt this Emergency Rule to have the additional tool for law enforcement in place until the corresponding permanent rules can be adopted to allow law enforcement to verify liability insurance coverage real-time on the roadside driver's license plate, and for the Office of Motor Vehicles to have the most accurate insurance information available in connection with enforcement of Louisiana's compulsory insurance laws. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and is adopted on the date signed by the undersecretary for the department, and shall take effect August 20, 2015, and be in effect for the maximum period allowed under the law, 120 days, or until adoption of the final Rule, whichever occurs first.

This Emergency Rule adopts LAC 55:III, Chapter 17, Subchapter B, Compulsory Insurance Enforcement, §1751 through §1757 to implement the provisions of R.S. 32:863.2(A)(3) and (4) and R.S. 32:863.2(F)(6). These are completely new Sections.

The current LAC 55:III, Chapter 17, Subchapter B, Specifications for Notification of Initiation, Termination, or Modification of Liability Security, §1750 through §1792 is being repealed in its entirety.

Title 55

PUBLIC SAFETY

Part III. Motor Vehicles

Chapter 17. Compulsory Insurance

Subchapter B. Compulsory Insurance Enforcement

§1750. Definitions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2842 (December 2004), repealed LR 41:

§1751. Specifications for Notification of Initiation, Termination, or Modification of Liability Security

A. The Department of Public Safety and Corrections, Office of Motor Vehicles, hereby adopts by reference, the Section VII Policies and Procedures, Effective Date: August 20 2015, Specifications for Notification of Initiation, Termination or Modification of Liability Security, hereinafter referred to as the specifications.

B. A copy of these specifications shall be on file at the Division of Administration, Office of the State Register, 1201 North Third Street, Baton Rouge, LA 70802, and copies are available at the Office of Motor Vehicles Headquarters, 7979 Independence Blvd., Ste. 301, Baton Rouge, LA 70806 or P.O. Box 64886, Baton Rouge, LA 70896.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1752. Introduction

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004), repealed LR 41:

§1753. Guide for Real-Time System to Identify and Verify the Existence of Motor Vehicle Insurance or Other Security

A. The Department of Public Safety and Corrections, Office of Motor Vehicles, hereby adopts by reference, the Louisiana Insurance Verification System (LAIVS), Implementation Guide for Insurance Providers, effective date: August 20, 2015, hereinafter referred to as the LAIVS Implementation Guide.

B. A copy of the LAIVS Implementation Guide shall be on file at the Division of Administration, Office of the State Register, 1201 North Third Street, Baton Rouge, LA 70802, and copies are available at the Office of Motor Vehicles Headquarters, 7979 Independence Blvd., Ste. 301, Baton Rouge, LA 70806 or P.O. Box 64886, Baton Rouge, LA 70896.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1754. General Information

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2845 (December 2004), repealed LR 41:

§1755. Model User Guide for Implementing Online Insurance Verification

A. The Department of Public Safety and Corrections, Office of Motor Vehicles, hereby adopts by reference, the Model User Guide for Implementing Online Insurance Verification—Using Web Services to verify evidence of auto

liability insurance, Version 5.0 April 18, 2012, by the Insurance Industry Committee on Motor Vehicle Administration Effective Date: August 20 2015, hereinafter referred to as the model user guide.

B. A copy of the model user guide shall be on file at the Division of Administration, Office of the State Register, 1201 North Third Street, Baton Rouge, LA 70802, and copies are available at the Office of Motor Vehicles Headquarters, 7979 Independence Blvd., Ste. 301, Baton Rouge, LA 70806 or P.O. Box 64886, Baton Rouge, LA 70896.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1756. Manual Filings

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:28:2846 (December 2004), repealed LR 41:

§1757. Declaratory Orders and Rulings [Formerly §1789]

A. Any person desiring a ruling on the applicability of R.S. 32:863.2, or any other statute, or the applicability or validity of any rule, to the reporting of initiation and any subsequent change in insurance coverage shall submit a written petition to the assistant secretary for the Office of Motor Vehicles. The written petition shall cite all constitutional provisions, statutes, ordinances, cases, and rules which are relevant to the issue presented or which the person wishes the assistant secretary to consider prior to rendering an order or ruling in connection with the petition. The petition shall be typed, printed or written legibly, and signed by the person seeking the ruling or order. The petition shall also contain the person's full printed name, the complete physical and mailing address of the person, and a daytime telephone number.

B. If the petition seeks an order or ruling on a report submitted to the Office of Motor Vehicles by a security provider, the person submitting the petition shall notify the security provider who submitted the report, if the person submitting the petition is not the security provider. Such notice shall be sent by certified mail, return receipt requested. In such case, the petition shall not be considered until proof of such notice has been submitted to the assistant secretary, or until the person petitioning for the order or ruling establishes that the security provider cannot be notified after a due and diligent effort. The notice shall include a copy of the petition submitted to the assistant secretary.

C. The assistant secretary may request the submission of legal memoranda to be considered in rendering any order or ruling. The assistant secretary or his designee shall base the order or ruling on the documents submitted including the petition and legal memoranda. If the assistant secretary or his designee determines that the submission of evidence is necessary for a ruling, the matter may be referred to a hearing officer prior to the rendering of the order or ruling for the taking of such evidence.

D. Notice of the order or ruling shall be sent to the person submitting the petition as well as the security

provider receiving notice of the petition at the mailing addresses provided in connection with the petition.

E. The assistant secretary may decline to render an order or ruling if the person submitting the petition has failed to comply with any requirement in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 24:1780 (September 1998), repromulgated LR 30:2856 (December 2004), repromulgated LR 41:

§1758. Fleet Filings

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2846 (December 2004), repealed LR 41:

§1760. Fee Assessments

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2846 (December 2004), repealed LR 41:

§1762. Transaction Types and How They Are Used

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2846 (December 2004), repealed LR 41:

§1764. Disposition Codes

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2847 (December 2004), repealed LR 41:

§1766. Contact Person Information

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2847 (December 2004), repealed LR 41:

§1768. Reporting Instructions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2848 (December 2004), repealed LR 41:

§1770. General Information

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2848 (December 2004), repealed LR 41:

§1772. File Transfer

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2848 (December 2004), repealed LR 41:

§1774. Record Processing

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2849 (December 2004), repealed LR 41:

§1776. Record Formats

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2849 (December 2004), repealed LR 41:

§1778. Header Record

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2849 (December 2004), repealed LR 41:

§1780. Individual Vehicle Filing Record

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2850 (December 2004), repealed LR 41:

§1782. Approved Reporting Methods

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2852 (December 2004), repealed LR 41:

§1784. Fleet Filing Record

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2853 (December 2004), repealed LR 41:

§1786. Trailer Record

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2854 (December 2004), repealed LR 41:

§1788. Invalid Vehicle Type-Use

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2856 (December 2004), repealed LR 41:

§1789. Declaratory Orders and Rulings

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 24:1780 (September 1998), repromulgated LR 30:2856 (December 2004), repealed LR 41:

§1790. Identification Card Specifications

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2856 (December 2004), repealed LR 41:

§1792. Proof of Liability Security

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2858 (December 2004), repealed LR 41:

Jill P. Boudreaux
Undersecretary

1509#006

DECLARATION OF EMERGENCY

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

Red Snapper Recreational Harvest

The established season for the recreational harvest of red snapper in Louisiana state waters as outlined in LAC 76:VII.335 is from the Saturday preceding Palm Sunday, open on weekends only, where Friday, Saturday, Sunday, and the Monday of Memorial Day and the Monday of Labor Day are defined as weekend days, through September 30 of each year. The bag and possession limit, as established in LAC 76:VII.335 is 3 red snapper per person per day. The season was modified on March 20, 2015 to be open every day of the week with a 2 red snapper bag and possession limit at the established minimum length of 16 inches until further notice. The season is hereby closed effective from 12:01 a.m. on September 8, 2015.

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, and the authority given to the secretary of the department by the commission in LAC 76:VII.335.G.5 to modify the recreational red snapper seasons and possession limits in Louisiana state waters when he deems necessary, the secretary hereby declares:

The recreational fishery for the harvest of red snapper in Louisiana state waters will close at 12:01 a.m. on September 8, 2015. Effective with this closure, no person shall recreationally harvest or possess red snapper whether within or without Louisiana water.

Robert Barham
Secretary

1509#002

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Oyster Season—2015/2016

In accordance with the emergency provisions of the Administrative Procedure Act, Louisiana Revised Statutes (R.S.) 49:953, and under the authority of R.S. 56:433, R.S. 56:435.1, and R.S. 56:435.1.1(D) notice is hereby given that the secretary of the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission hereby declare the 2015/2016 oyster season as follows:

The Little Lake Public Oyster Seed Grounds, as described in *Louisiana Administrative Code* (LAC) 76:VII:521, the Barataria Bay, Deep Lake, and Lake Tambour public oyster seed grounds, as described in LAC 76:VII:517, and the Vermilion/East and West Cote Blanche Bay/Atchafalaya Bay Public Oyster Seed Grounds, as described in LAC 76:VII:507 and 76:VII:509 shall open one-half hour before sunrise on Wednesday, September 9, 2015. As per R.S. 56:433(B)(1), no harvest of oysters for market sales is allowed on any public oyster area prior to the second Monday in October, which is October 12, 2015. Therefore, any and all vessels harvesting on the open public oyster seed grounds between September 9, 2015 and October 11, 2015, both dates inclusive, shall be harvesting seed oysters for bedding purposes only and shall not have sacks or other containers typically used to hold oysters on board the harvest vessel.

All remaining public oyster seed grounds and reservations, as described in R.S. 56:434, LAC 76:VII.511, LAC 76:VII.513, and LAC 76:VII.517, including Lake Borgne, Bay Gardene, Hackberry Bay, Lake Chien, Lake Felicity, Sister Lake, Lake Mechant, and the sacking-only area in the American Bay area, which is that portion of the public grounds within Bay Long west of a line running generally north/south from a point at 29 degrees 31 minutes 13.78 seconds N latitude, 89 degrees 34 minutes 9.79 seconds W longitude to a point at 29 degrees 29 minutes 40.67 seconds N latitude, 89 degrees 34 minutes and 8.48 seconds W longitude, shall open at one-half hour before sunrise on Monday, October 19, 2015.

During the 2015/2016 open oyster season, the following provisions shall be in effect:

1. the take of oysters from the Louisiana Department of Health and Hospitals' shellfish harvest area 2 (Mississippi Sound) shall be restricted to harvest for market sales only (sacking-only);

2. any vessel from which any person(s) takes or attempts to take oysters from the public oyster seed grounds and reservations described above shall:

a. be limited to a daily take and possession limit not to exceed 50 sacks of oysters per vessel, except for in the Sister Lake public oyster seed reservation where the limit shall not exceed 40 sacks per vessel and except for in the West Cove portion of Calcasieu Lake where the limit shall not exceed 7 sacks per person per vessel per day. A sack of oysters for the purposes of this declaration of emergency shall be defined as the size described in R. S. 56:440. The daily take and possession limit shall not apply to vessels harvesting seed oysters for bedding purposes. The

possession limit shall not apply to vessels operating under a valid oyster cargo vessel permit;

b. be limited to either harvesting market oysters for direct sale (sacking) or harvesting seed oysters for bedding purposes on any one day and is specifically prohibited from doing both;

3. if any person on a vessel takes or attempts to take oysters from the public oyster seed grounds or reservations described above, all oysters contained on that vessel shall be deemed to have been taken from said seed ground or reservation from the time harvest begins until all oysters are off-loaded dockside.

The oyster season in the west cove portion of the Calcasieu Lake public oyster area, as described in R.S. 56:435.1.1, shall open one-half hour before sunrise on Sunday, November 1, 2015. The sack limit for west cove portion of Calcasieu Lake is set at 7 sacks per person per vessel per day as provided for in R.S. 56:435.1.1. However, these conservation actions shall not supersede public health closures.

The following areas shall remain closed for the entire 2015/2016 oyster season:

1. the 2014 Hackberry Bay Cultch Plant within the following coordinates:

- a. 29 degrees 25 minutes 23.58 seconds
90 degrees 01 minutes 21.00 seconds
- b. 29 degrees 25 minutes 16.43 seconds
90 degrees 01 minutes 14.59 seconds
- c. 29 degrees 25 minutes 07.91 seconds
90 degrees 01 minutes 27.41 seconds
- d. 29 degrees 25 minutes 15.33 seconds
90 degrees 01 minutes 33.71 seconds

2. the Bay Junop public oyster seed reservation;

3. the east side of the Calcasieu Lake public oyster area;

4. the 2015 Calcasieu Lake West Cove Cultch Plant within the following coordinates:

- a. 29 degrees 52 minutes 39.66 seconds
93 degrees 23 minutes 42.14 seconds
- b. 29 degrees 52 minutes 28.94 seconds
93 degrees 23 minutes 42.20 seconds
- c. 29 degrees 52 minutes 39.60 seconds
93 degrees 23 minutes 31.92 seconds
- d. 29 degrees 52 minutes 29.01 seconds
93 degrees 23 minutes 31.92 seconds

e. Sabine Lake Public oyster area (as described in R.S. 56:435.1).

The secretary of the Department of Wildlife and Fisheries is authorized to take emergency action as necessary to:

1. close areas if oyster mortalities are occurring or to delay the season or close areas where significant spat catch has occurred with good probability of survival, or where it is found that there are excessive amounts of non-living reef material in seed oyster loads, or if oyster resources and/or reefs are being adversely impacted, or if enforcement problems are encountered; and

2. adjust daily take and/or possession limits as biological or enforcement data indicate a need; and

3. adjust sacking-only areas and/or restrict the taking of seed oysters as biological or enforcement data indicate a need;

4. reopen an area previously closed if the threat to the resource has ended, or may open areas if substantial oyster resources are located.

The secretary shall notify the chairman of the Wildlife and Fisheries Commission of his intention to make any or all of the changes indicated above.

Notice of any opening, delaying or closing of a season will be made by public notice at least 72 hours prior to such action unless such closure is ordered by the Louisiana Department of Health and Hospitals for public health concerns.

Pat Manuel
Chairman

1509#054

DECLARATION OF EMERGENCY

Workforce Commission Office of Workers' Compensation Administration

Employment Based Fifth Category Visa Program (EB-5)
Certification of High Unemployment Areas
(LAC 40:XXI.101)

This Emergency Rule is being published pursuant to emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), and R.S. 36:310. The Louisiana Workforce Commission has an immediate need for a rule for certification requests of high unemployment areas for the federal Employment Based Fifth Category Visa Program (EB-5) pursuant to 8 CFR Part 204.6(i) to effect fees as the designated agency. A delay in imposition of such fees would hinder effective administration of this program, impose unfunded and unrecoverable costs on the department, and delay access to the program by qualified applicants, resulting in an adverse financial impact on the state, the department, Louisiana businesses and taxpayers. This Emergency Rule shall become effective on September 20, 2015, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act, or until a final Rule is adopted under the nonemergency rulemaking procedures of the Administrative Procedure Act, whichever occurs first.

Title 40

LOUISIANA WORKFORCE COMMISSION

Part XXI. High Unemployment Areas

Chapter 1. Certification of High Unemployment Areas

§101. Application Fee

A. An application fee in the amount of \$250 shall be required for each request for certification of a high unemployment area under the Employment Based Fifth Category Visa Program (EB-5).

B. All fees shall be paid in advance by check, money order, or other authorized method of payment and made payable to: Louisiana Workforce Commission. Cash cannot be accepted.

AUTHORITY NOTE: Promulgated in accordance with 8 CFR Part 204.6(i) and R.S. 36:310.

HISTORICAL NOTE: Promulgated by the Workforce Commission, Office of Workforce Development, LR 41:

Curt Eysink
Executive Director

1509#033

DECLARATION OF EMERGENCY

Workforce Commission Office of Workers' Compensation Administration

Medical Treatment Guidelines
(LAC 40:I.2519, 2701, 2705, 2707,
2718, 5101, 5113, 5315, and 5399)

The Louisiana Workforce Commission has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedure Act to amend certain portions of the Medical Guidelines contained in the *Louisiana Administrative Code*, Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapters 25-53. This Emergency Rule effective October 1, 2015, will remain in effect for a period of 120 days.

This amendment is required to stay in compliance with the federal Protecting Access to Medicare Act of 2014. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Department of Health and Human Services set the compliance date for October 1, 2015. This does not affect CPT coding for outpatient procedures and physician services.

The department considers emergency action necessary to facilitate an efficient and timely transition to ICD-10 medical coding, pending enactment of a rule through regular administrative procedure. Notice is hereby given, in accordance with R.S. 49:950, et seq., that the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to authority vested in the Director of the Office of Workers' Compensation by R.S. 23:1291 and 23:1310.1, and in accordance with applicable provisions of the Administrative Procedure Act, proposes to amend LAC 40:I., Subpart 2, Chapters 25-53.

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Subpart 2. Medical Guidelines

Chapter 25. Hospital Reimbursement Schedule, Billing Instruction and Maintenance Procedures

Editor's Note: Other Sections applying to this Chapter can be found in Chapter 51.

§2519. Outlier Reimbursement and Appeals Procedures

A. Automatic Outliers. Inpatient hospital acute care services falling within certain diagnosis code ranges will be reimbursed outside the normal per diem reimbursement method. These atypical admissions will be paid at covered billed charges less a 15 percent discount. Conditions requiring acute care inpatient hospital services that are work-related and are recognized as "automatic outliers" are:

1. AIDS: ICD-10 Diagnosis Code B20;
2. Acute Myocardial Infarction: ICD10 Diagnosis Codes: I2109; I220; I2101; I2102; I2119; I221; I2111; I2129; I228; I2121; I228; I213; I229; and

3. Severe Burns: ICD-10 Diagnosis Codes: T2650XA, T2651XA, T2652XA; T2600XA, T2601XA, T2602XA; T2660XA, T2661XA, T2662XA; T2660XA, T2610XA, T2611XA, T2612XA; T2620XA, T2621XA, T2622XA; T2630XA, T2631XA, T2632XA, T2640XA, T2641XA, T2642XA, T2680XA, T2681XA, T2682XA, T2690XA, T2691XA, T2692XA; T2030XA, T2070XA; T20311A, T20312A, T20319A, T20711A, T20712A, T20719A; T2032XA, T2072XA; T2033XA, T2073XA; T2034XA, T2074XA; T2035XA, T2075XA; T2036XA, T2076XA; T2037XA, T2077XA; T2039XA, T2079XA; T2670XA, T2671XA, T2672XA; T2130XA, T2170XA; T2131XA, T2171XA; T2132XA, T2172XA; T2133XA, T2134XA, T2135XA, T2173XA, T2174XA, T2175XA, T2136XA, T2176XA; T2139XA, T2179XA; T2230XA, T2270XA; T22311A, T22312A, T22319A, T22711A, T22712A, T22719A; T22321A, T22322A, T22329A, T22721A, T22722A, T22729A; T22331A, T22332A, T22339A, T22731A, T22732A, T22739A; T22341A, T22342A, T22349A, T22741A, T22742A, T22749A; T22351A, T22352A, T22359A, T22751A, T22752A, T22759A; T22361A, T22362A, T22369A, T22761A, T22762A, T22769A; T22391A, T22392A, T22399A, T22791A, T22792A, T22799A; T23301A, T23302A, T23309A, T23701A, T23702A, T23709A; T23321A, T23322A, T23329A, T23721A, T23722A, T23729A; T23311A, T23312A, T23319A, T23711A, T23712A, T23719A; T23331A, T23332A, T23339A, T23731A, T23732A, T23739A; T23341A, T23342A, T23349A, T23741A, T23742A, T23749A, T23351A, T23352A, T23359A, T32751A, T23752A, T23759A, T23361A, T23362A, T23369A, T23761A, T23762A, T23769A, T23371A, T23372A, T23379A, T23771A, T23772A, T23779A, T23391A, T23392A, T23399A, T23791A, T23792A, T23799A, T23301A, T23302A, T23309A, T23701A, T23702A, T23709A, T23321A, T23322A, T23329A, T23721A, T23722A, T23729A; T24301A, T24302A, T24309A, T24701A, T24702A, T24709A; T25331A, T25332A, T25339A, T25731A, T25732A, T25739A; T25321A, T25322A, T25329A, T25721A, T25722A, T25729A; T25311A, T25312A, T25319A, T25711A, T25712A, T25719A; T24331A, T24332A, T24339A, T24731A, T24732A, T24739A; T24321A, T24322A, T24329A, T24721A, T24722A, T24729A; T24311A, T24312A, T24319A, T24711A, T24712A, T24719A; T24391A, T24392A, T24399A, T24791A, T24792A, T24799A, T25391A, T25392A, T25399A, T25791A, T25792A, T25799A; T300; T304; T270XXA, T271XXA, T273XXA, T274XXA, T275XXA, T276XXA, T277XXA; T281XXA, T286XXA; T282XXA, T287XXA; T283XXA, T28411A, T28412A, T28419A, T2849XA, T288XXA, T28911A, T28912A, T28919A, T2899XA; T310, T320; T3110, T3210; T3111, T3211; T3120, T3220; T3121, T3221; T3122, T3222; T3130, T3230; T3131, T3231; T3132, T3232; T3133, T3233; T3140, T3240; T3143, T3243; T3144, T3244; T3150, T3250; T3152, T3252; T3151, T3251; T3154, T3254; T3153, T3253; T3155, T3255; T3160, T3260; T3161, T3261; T3162,

T3262; T3163, T3263; T3164, T3264; T3165, T3265; T3166, T3266; T3170, T3270; T3171, T3271; T3172, T3272; T3173, T3273; T3174, T3274; T3175, T3275; T3176, T3276; T3177, T3277; T3180, T3280; T3181, T3281; T3182, T3282; T3183, T3283; T3184, T3284; T3185, T3285; T3186, T3286; T3187, T3287; T3188, T3288; T3190, T3290; T3191, T3291; T3192, T3292; T3191, T3293; T3194, T3294; T3196, T3296; T3195, T3295; T3197, T3297; T3198, T3298; T3199, T3299.

B. Appeal Procedures. Special reimbursement consideration will be given to cases that are atypical in nature due to case acuity causing unusually high charges when compared to the provider's usual case mix. This appeal process applies to workers' compensation cases paid under the per diem reimbursement formula limiting the payment amount to the lesser of per diem or covered billed charges.

1. - 7.a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR 41:981 (May 2015), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

Chapter 27. Utilization Review Procedures

§2701. Statement of Policy

A. - B.3. ...

4. Statements of charges shall be made in accordance with standard coding methodology as established by these rules, ICD-10-CM, ICD-10-PCS, HCPCS, and CPT-4 coding manuals. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the purpose of inflating bills or reimbursement is strictly prohibited. Services must be coded and charged in the manner guaranteeing the lowest charge applicable. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.

5. - 7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

§2705. Pre-Admission Certification

Editor's Note: The telephone number for the Office of Workers' Compensation has been changed to (225) 342-9836.

A. - B. ...

C. Louisiana Office of Worker's Compensation Administration shall support both ICD-9 and ICD-10 coding formats for a period of time after the compliance date. Claims shall be accepted with ICD-9 codes for service dates or discharge dates prior to the compliance date for pre-authorized services and/or treatment or timely filing requirements. If an authorization is requested on or before

the compliance date, and the date of service is on or after October 1, 2015, healthcare professionals must submit an ICD-10 code. If an authorization is requested after the compliance date, the ICD-10 code will be required. The pre-admission certification process follows the sequence below.

- 1. - 1.i. ...
 - j. admitting diagnosis (to include ICD-10-CM codes);*
 - k. ...
 - l. major procedures and related CPT/ICD-10 -PCS codes;*
 - m. - v. ...
- *The provider will provide descriptive/narrative information and the reviewer, representing the carrier/self-insured employer, will provide the ICD-10-CM, ICD-10-PCS and/or CPT-4 codes.

D. - E.2.b. ...

3. Evaluation

- a. ...
- b. Carrier/Self-Insured Employer Data Reporting. Carrier/self-insured employer will be required to collect the following data according to the Office of Workers' Compensation Administration requirements.

Information	Positions	Type
/ICD-10-CM	5/7	Numeric
Provider Name	30	Alpha
Provider Street Address	30	Alpha Numeric
Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3	Numeric
Place of Treatment	1	Alpha Numeric
Type of Facility*	6	Numeric
Type of Service: Medical vs. Surgical	1	Alpha Numeric
Claimant Name	30	Alpha
Claimant Social Security Number	9	Numeric
Length of Stay	4	Numeric
*See "Type Facility Codes" in Exhibit 6.		

c. - e. ...

* * *

§2718. Utilization Review Forms

- A. LWC Form 1010—Request of Authorization/Carrier or Self Insured Employer Response

LWC FORM 1010—REQUEST OF AUTHORIZATION/ CARRIER OR SELF INSURED EMPLOYER RESPONSE			
PLEASE PRINT OR TYPE			
SECTION 1. IDENTIFYING INFORMATION - To Be Filled Out By Health Care Provider			
PATIENT	Last Name: First:		Street Address, City, State, Zip:
	Middle:		
	Last Four Digits of Social Security Number:	Date of Birth:	Phone Number: Date of Injury:
Employers Name:		Street Address, City, State, Zip:	Phone Number:

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

§2707. Admission and Continued Stay Review

Editor's Note: The telephone number for the Office of Workers' Compensation has been changed to (225) 342-9836.

- A. - E.2.b. ...
- 3. Evaluation

- a. ...
- b. Carrier/Self-Insured Employer Data Reporting. Carrier/self-insured employer will be required to collect data according to the Office of Workers' Compensation Administration requirements.

Information	Positions	Type
/ICD-10-CM	5/7	Numeric
Provider Name	30	Alpha
Provider Street Address	30	Alpha Numeric
Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3	Numeric
Place of Treatment	1	Alpha Numeric
Type of Facility*	6	Numeric
Type of Service: Medical vs. Surgical	1	Alpha Numeric
Claimant Name	30	Alpha
Claimant Social Security Number	9	Numeric
Length of Stay	4	Numeric
* See "Type Facility Codes" in Exhibit 6.		

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

**LWC FORM 1010—REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE
PLEASE PRINT OR TYPE**

CARRIER	Name:	Adjuster:	Claim Number (if known):	
	Street Address, City, State Zip:	Email Address:	Phone Number:	Fax Number:

SECTION 2. REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider

PROVIDER	Requesting Health Care Provider	Phone Number:	Fax Number:
	Street Address, City, State Zip:	Email:	
	Diagnosis:	CPT/DRG Code:	ICD-10-CM/ DSM-V Code:
	Requested Treatment or Testing (Attach Supplement If Needed):		
	Reason for Treatment or Testing (Attach Supplement If Needed):		

INFORMATION REQUIRED BY RULE TO BE INCLUDED WITH REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider

(Following is the required minimum information for Request of Authorization (LAC 40:2715 (C))

PROVIDER	<input type="checkbox"/>	History provided to the level of condition and as provided by Medical Treatment Schedule
	<input type="checkbox"/>	Physical Findings/Clinical Tests
	<input type="checkbox"/>	Documented functional improvements from prior treatment
	<input type="checkbox"/>	Test/imaging results
	<input type="checkbox"/>	Treatment Plan including services being requested along with the frequency and duration
I hereby certify that this completed form and above required information was		to the Carrier/Self Insured Employer on this the
		<input type="checkbox"/> Faxed <input type="checkbox"/> Emailed
		_____ day of _____, _____ (day) (month) (year)

**LWC FORM 1010—REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE**

PLEASE PRINT OR TYPE

Signature of Health Care Provider:

Printed Name:

SECTION 3. RESPONSE OF CARRIER/SELF INSURED EMPLOYER FOR AUTHORIZATION
(Check appropriate box below and return to requesting Health Care Provider, Claimant and Claimant Attorney as provided by rule)

CARRIER

The requested Treatment or Testing is **approved**

The requested Treatment or Testing is **approved with modifications** (Attach summary of reasons and explanation of any modifications)

The requested Treatment or Testing is **denied** because

Not in accordance with Medical Treatment Schedule or R.S.23:1203.1(D)
(Attach summary of reasons)

The request, or a portion thereof, is not related to the on-the-job injury

The claim is being denied as non-compensable

Other (Attach brief explanation)

I hereby certify that this response of Carrier/Self Insured Employer for Authorization was

to the Health Care Provider (and to the Attorney of Claimant if one exists, if denied or approved with modification) on this the

**LWC FORM 1010—REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE**

PLEASE PRINT OR TYPE

		<input type="checkbox"/> Faxed	____ day of ____, ____ (day) (month) (year)
		<input type="checkbox"/> Emailed	
Signature of Carrier/Self Insured Employer:		Printed Name:	
<input type="checkbox"/> The prior denied or approved with modification request is now approved			
I hereby certify that this response of Carrier/Self Insured Employer for Authorization was	<input type="checkbox"/> Faxed	to the Health Care Provider and Attorney of Claimant if one exists on this the ____ day of ____, ____ (day) (month) (year)	
	<input type="checkbox"/> Emailed		
Signature of Carrier/Self Insured Employer:		Printed Name:	

SECTION 4. FIRST REQUEST

(Form 1010A is required to be filled out by Carrier/Self Insured Employer and Health Care Provider)

CARRIER		<input type="checkbox"/> The requested Treatment or Testing is delayed because minimum information required by rule was not provided		
	I hereby certify that this First Request and accompanying Form 1010A was	<input type="checkbox"/> Faxed	to the Health Care Provider on this the ____ day of ____, ____ (day) (month) (year)	
		<input type="checkbox"/> Emailed		

**LWC FORM 1010—REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE
PLEASE PRINT OR TYPE**

	Signature of Carrier/Self Insured Employer:		
PROVIDER	I hereby certify that a response to the First Request and accompanying Form 1010A was	<input type="checkbox"/> Faxed	to the Carrier/Self Insured Employer on this the _____ day of _____, _____ (day) (month) (year)
		<input type="checkbox"/> Emailed	
	Signature of Health Care Provider:		Printed Name:

SECTION 5. SUSPENSION OF PRIOR AUTHORIZATION DUE TO LACK OF INFORMATION

CARRIER	Suspension of Prior Authorization Process due to Lack of Information		
	<input type="checkbox"/> The requested Treatment or Testing is delayed due to a Suspension of Prior Authorization Due to Lack of Information		
PROVIDER	I hereby certify that this Suspension of Prior Authorization was	<input type="checkbox"/> Faxed	to the Health Care Provider on this the _____ day of _____, _____ (day) (month) (year)
		<input type="checkbox"/> Emailed	
	Signature of Carrier/Self Insured Employer:		Printed Name:

PROVIDER	Appeal of Suspension to Medical Services Section by Health Care Provider		
	I hereby certify that this form and all information previously submitted to Carrier/Self Insured Employer was faxed to OWCA Medical Services (Fax Number: 225-342-9836) this _____ day of _____, _____.		
	I hereby certify that this Appeal of Suspension of Prior Authorization was	<input type="checkbox"/> Faxed	to the Carrier/Self Insured Employer on this the _____ day of _____, _____ (day) (month) (year)

**LWC FORM 1010—REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE
PLEASE PRINT OR TYPE**

		<input type="checkbox"/> Emailed	
Signature of Health Care Provider:		Printed Name:	

SECTION 6. DETERMINATION OF MEDICAL SERVICES SECTION

OW/CA	<input type="checkbox"/> The required information of LAC40:2715(C) <i>was not</i> provided		
	<input type="checkbox"/> The required information of LAC40:2715(C) <i>was</i> provided		
	I hereby certify that a written determination was	<input type="checkbox"/> Faxed <input type="checkbox"/> Emailed	to the Health Care Provider & Carrier/Self Insured Employer on this the _____ day of _____, _____ (day) (month) (year)
	Signature:		Printed Name:

SECTION 7. HEALTH CARE PROVIDER RESPONSE TO MEDICAL SERVICES DETERMINATION

PROVIDER	I hereby certify that additional information, pursuant to the determination of Medical Services Section, was	<input type="checkbox"/> Faxed <input type="checkbox"/> Emailed	to the Carrier/Self Insured Employer on this the _____ day of _____, _____ (day) (month) (year)
	Signature of Health Care Provider:		Printed Name:

AUTHORITY NOTE: Promulgated in accordance with RS 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1037 (April 2012), amended LR 38:3255 (December 2012), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

Chapter 51 Medical Reimbursement Schedule

Editor's Note: The following Sections of this Chapter are applicable and shall be used for the Chapters in this Part governing reimbursement. These specific Chapters are: Chapter 25, Hospital Reimbursement; Chapter 29, Pharmacy; Chapter 31, Vision Care Services; Chapter 33, Hearing Aid Equipment and Services; Chapter 35, Nursing/Attendant Care and Home Health Services; Chapter 37, Home and Vehicle Modification; Chapter 39, Medical Transportation; Chapter 41, Durable Medical Equipment and Supplies; Chapter 43, Prosthetic and Orthopedic Equipment; Chapter 45, Respiratory Services; Chapter 47, Miscellaneous Claimant Expenses; Chapter 49, Vocational Rehabilitation Consultant; Chapter 51, Medical Reimbursement Schedule; and Chapter 53, Dental Care Services.

§5101. Statement of Policy

A. - B.3. ...

4. Statements of charges shall be made in accordance with standard coding methodology as established by these rules, ICD-10-CM, ICD-10-PCS, HCPCS, CPT-4, CDT-1, NDAS coding manuals. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the purpose of inflating bills or reimbursement is strictly prohibited. Services must be coded and charged in the manner guaranteeing the lowest charge applicable. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.

5. - 8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR 40:375 (February 2014), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

§5113. Coding System

A. Diagnosis Coding. *The International Classification of Diseases, Tenth Revision* (ICD-10-CM) is the basis of diagnosis coding. These are the disease codes in the international classification, tenth revision, clinical modifications published by the U.S. Department of Health and Human Resources.

B. Helpful Hints for Diagnosis Coding

1. - 2. ...

3. All digits of the appropriate ICD-10-CM code(s) should be reported.

4. The date of accident should always be reported if the ICD-10-CM code is for an accident diagnosis.

5. It is important to provide a complete description of the diagnosis if an appropriate ICD-10-CM code cannot be located.

C. - C.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993),

repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

Chapter 53. Dental Care Services, Reimbursement Schedule and Billing Instructions

Editor's Note: Other Sections applying to this Chapter can be found in Chapter 51.

§5315. Coding System

A. - A.6. ...

* * *

B. CDT-1 Coding

1. - 2. ...

3. Procedures denoted "BR" (by report) in the fee schedule should be justified by the submission of a report.

4. All fees should include the price of materials supplied and the performance of the service. Under some circumstances, however, fee adjustments are necessary and values of listed codes may be modified by use of the appropriate "modifier code number." Modifiers available:

22	Unusual Services—Report required.
50	Bilateral or Multiple Field Procedures—Multiple procedures in separate anatomical field. The following values may be used: 100 percent first major procedure. 70 percent each additional field procedure.
51	Multiple Procedures—Multiple procedure in the same anatomical field. The following values may be used: Single Field 100 percent for first major procedure 50 percent of listed value for second 25 percent of listed value for third 10 percent of listed value for fourth 5 percent of listed value for fifth BR for any procedure beyond 5
52	Reduced Values—Reduced or estimated value for procedure because of common practice or at the dentist's election.
53	Primary Emergency Services—Procedure is carried out by a dentist who will not be providing the follow-up care. The value may be 70 percent of the listed value.
54	Surgical Procedure Only—Used to identify the dentist performing surgery. The value may be 70 percent of the listed value.
55	Follow-Up Care Only—Identifies the dentist providing follow-up care. The value may be 30 percent of the listed value.
56	Pre-Operative Care Only—Identifies the dentist performing care up until surgery when another dentist takes over. Value may be 30 percent of the listed value.
75	Services Rendered by More than One Dentist—When the condition requires more than one dentist, each dentist may be allowed 80 percent of the value for that procedure
99	Multiple Modifiers- By Report
The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of medical necessity and must be determined on a case-by-case basis.	

5. Fees for surgical procedures should be global in nature and include the surgery, any local anesthesia and normal follow-up care. Fees for general anesthesia are extra as are complications or additional services and should be coded separately.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:1163 (September 1993), amended LR 20:1298 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR

§5399. Schedule for Maximum Allowances for Dental Services

CDT Code	Description	Maximum Reimbursement
D0120	Periodic oral evaluation—established patient	50
D0140	Limited oral evaluation—problem focused	75
D0145	Oral evaluation—patient under 3yrs & counseling with primary caregiver	69
D0150	Comprehensive oral evaluation—new or established patient	88
D0160	Detailed & Extensive oral evaluation—problem focused, by report	160
D0170	Re-evaluation—limited, problem focused (established patient; not post-operative visit)	70
D0180	Comprehensive periodontal evaluation—new or established patient	95
D0210	Intraoral—complete series (including bitewings)	128
D0220	Intraoral—periapical first film	28
D0230	Intraoral—periapical each additional film	24
D0240	Intraoral—occlusal films	42
D0250	Intraoral—first film	67
D0260	Extraoral—first film	55
D0270	Bitewing—single film	28
D0272	Bitewing—two films	45
D0273	Bitewing—three films	55
D0274	Bitewing—four films	65
D0277	Vertical bitewings—7 to 8 films	97
D0290	Posterior-anterior or lateral skull & facial bone survey film	135
D0310	Sialography	389
D0320	Temporomandibular joint films, including injection	592
D0321	Other temporomandibular joint films, by report	210
D0322	Tomographic survey	530
D0330	Panoramic film	110
D0340	Cephalometric film	125
D0350	Oral/facial photographic images	71
D0360	Cone beam CT—craniofacial data capture	589
D0362	Cone beam CT—two-dimensional image reconstruction using existing data, includes multiple images	359
D0363	Cone beam CT—three-dimensional image reconstruction using existing data, includes multiple images	398
D0415	Collection of microorganisms for culture and sensitivity	186
D0416	Viral culture	168
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	167
D0418	Analysis of saliva sample	150
D0421	Genetic test for susceptibility to oral diseases	136
D0425	Caries susceptibility tests	95
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	71
D0460	Pulp vitality tests	55
D0470	Diagnostic casts	109
D0472	Accession of tissue, gross examination, preparation and transmission of written report	118
D0473	Accession of tissue, gross examination and microscopic examination, preparation and transmission of written report	165

CDT Code	Description	Maximum Reimbursement
D0474	Accession of tissue, gross examination and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report	184
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	176
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	150
D0475	Decalcification procedure	195
D0476	Special stains for microorganisms	289
D0477	Special stains not for microorganisms	296
D0478	Immunohistochemical stains	175
D0479	Tissue in-situ hybridization, including interpretation	231
D0481	Electron microscopy—diagnostic	188
D0482	Direct immunofluorescence	105
D0483	Indirect immunofluorescence	123
D0484	Consultation on slides prepared elsewhere	168
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	180
D0502	Other oral pathology procedures, by report	170
D0999	Unspecified diagnostic procedure, by report	BR
D1110	Prophylaxis—adult	90
D1120	Prophylaxis—child	66
D1203	Topical application of fluoride—child	37
D1204	Topical application of fluoride—adult	37
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	45
D1310	Nutritional counseling for control of dental disease	70
D1320	Tobacco counseling for the control and prevention of oral disease	82
D1330	Oral hygiene instructions	55
D1351	Sealant—per tooth	54
D1352	Preventative resin restoration in a moderate to high caries risk patient—permanent tooth	BR
D1510	Space maintainer—fixed—unilateral	317
D1515	Space maintainer—fixed—bilateral	432
D1520	Space maintainer—removable—unilateral	390
D1525	Space maintainer—removable—bilateral	495
D1550	Re-cementation of space maintainer	83
D1555	Removal of fixed space maintainer	79
D2140	Amalgam—one surface, primary or permanent	138
D2150	Amalgam—two surfaces, primary or permanent	176
D2160	Amalgam—three surfaces, primary or permanent	214
D2161	Amalgam—four surfaces, primary or permanent	251
D2330	Resin-based composite—one surface, anterior	160
D2331	Resin-based composite—two surfaces, anterior	200
D2332	Resin-based composite—three surfaces, anterior	249
D2335	Resin-based composite—four or more surfaces or involving incisal angle (anterior)	312
D2390	Resin-based composite crown—anterior	450
D2391	Resin-based composite—one surface, posterior	177
D2392	Resin-based composite—two surfaces, posterior	230
D2393	Resin-based composite—three surfaces, posterior	284

CDT Code	Description	Maximum Reimbursement
D2394	Resin-based composite—four or more surfaces posterior	341
D2410	Gold foil—one surface	635
D2420	Gold foil—two surfaces	692
D2430	Gold foil—three surfaces	806
D2510	Inlay—metallic—one surface	833
D2520	Inlay—metallic—two surfaces	892
D2530	Inlay—metallic—three or more surfaces	965
D2542	Onlay—metallic—two surfaces	990
D2543	Onlay—metallic—three surfaces	1015
D2544	Onlay—metallic—four or more surfaces	1050
D2610	Inlay—porcelain/ceramic—one surface	907
D2620	Inlay—porcelain/ceramic—two surfaces	950
D2630	Inlay—porcelain/ceramic—three or more surfaces	995
D2642	Onlay—porcelain/ceramic—two surfaces	1008
D2643	Onlay—porcelain/ceramic—three surfaces	1049
D2644	Onlay—porcelain/ceramic—four or more surfaces	1094
D2650	Inlay—resin based—one surface	869
D2651	Inlay—resin based—two surfaces	904
D2652	Inlay—resin based—three or more surfaces	940
D2662	Onlay—resin based—two surfaces	944
D2663	Onlay—resin based—three surfaces	983
D2664	Onlay—resin based—four or more surfaces	1025
D2710	Crown—resin-based composite (indirect)	940
D2712	Crown—3/4 resin-based composite (indirect)	999
D2720	Crown—resin with high noble metal	1061
D2721	Crown—resin with predominantly base metal	998
D2722	Crown—resin with noble metal	1015
D2740	Crown—porcelain/ceramic substrate	1132
D2750	Crown—porcelain fused to high noble metal	1100
D2571	Crown—porcelain fused predominantly base metal	1029
D2752	Crown—porcelain fused to noble metal	1050
D2780	Crown—3/4 cast high noble metal	1063
D2781	Crown—3/4 cast predominantly base metal	1027
D2782	Crown—3/4 cast noble metal	1030
D2783	Crown—3/4 porcelain /ceramic	1100
D2790	Crown—full cast high noble metal	1100
D2791	Crown—full cast predominantly base metal	997
D2792	Crown—full cast noble metal	1045
D2794	Crown—titanium	1076
D2799	Provisional crown	437
D2910	Recement inlay, only, or partial coverage restoration	108
D2915	Recement cast or prefabricated post and core	114
D2920	Recement crown	109
D2930	Prefabricated stainless steel crown—primary tooth	271
D2931	Prefabricated stainless steel crown—permanent tooth	325
D2932	Prefabricated resin crown	351
D2933	Prefabricated stainless steel crown with resin window	363
D2934	Prefabricated esthetic coated stainless tell crown—primary tooth	372
D2940	Protective restoration	120
D2950	Core buildup, including any pins	271
D2951	Pin retention—per tooth, in addition to restoration	75
D2952	Post and core in addition to crown, indirectly fabricated	422
D2953	Each additional indirectly fabricated post—same tooth	312
D2954	Prefabricated post and core in addition to crown	335

CDT Code	Description	Maximum Reimbursement
D2955	Post removal (not in conjunction with endodontic therapy)	291
D2957	Each additional prefabricated post—same tooth	200
D2960	Labial veneer (resin laminate)—chairside	658
D2961	Labial veneer (resin laminate)—laboratory	975
D2962	Labial veneer (porcelain laminate)—laboratory	1150
D2970	Temporary crown (fractured tooth)	375
D2971	Additional procedures to construct new crown under existing partial denture framework	169
D2975	Coping	597
D2980	Crown repair, by report	293
D2999	Unspecified restorative procedure, by report	BR
D3110	Pulp cap—direct (excluding final restoration)	83
D3120	Pulp cap—indirect (excluding final restoration)	84
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament	198
D3221	Pulpal debridement, primary and permanent teet	234
D3222	Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development	298
D3230	Pulpal therapy (resorbable filling)—anterior , primary tooth (excluding final restoration)	275
D3240	Pulpal therapy (resorbable filling)—posterior , primary tooth (excluding final restoration)	312
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	725
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	842
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1009
D3331	Treatment of root canal obstruction: non-surgical access	611
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	444
D3333	Internal root reperi of perforation defects	350
D3346	Retreatment of previous root canal therapy—anterior	850
D3347	Retreatment of previous root canal therapy—bicuspid	970
D3348	Retreatment of previous root canal therapy—molar	1132
D3351	Apexification/recalcification/pulpal regeneration—initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc)	362
D3352	Apexification/recalcification/pulpal regeneration—interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc)	258
D3353	Apexification/recalcification/pulpal regeneration—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc)	542
D3354	Pupal regeneration—(completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	BR
D3410	Apicoectomy/periradicular surgery— anterior	700
D3421	Apicoectomy/periradicular surgery— bicuspid (first root)	780

CDT Code	Description	Maximum Reimbursement
D3425	Apicoectomy/periradicular surgery—molar (first root)	895
D3426	Apicoectomy/periradicular surgery—(each additional root)	400
D3430	Retrograde filling—per root	280
D3450	Root amputation—per root	483
D3460	Endodontic endosseous implant	1524
D3470	Intentional reimplantation (including necessary splinting)	796
D3910	Surgical procedure for isolation of tooth with rubber dam	235
D3920	Hemisection (including any root removal), not including root canal therapy	474
D3950	Canal preparation and fitting of preformed dowel or post	258
D3999	Unspecified endodontic procedure, by report	BR
D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	626
D4211	Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	290
D4230	Anatomical crown exposure—four or more contiguous teeth per quadrant	698
D4231	Anatomical crown exposure—one to three contiguous teeth per quadrant	596
D4240	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces per quadrant	738
D4241	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces per quadrant	635
D4245	Apically positioned flap	819
D4249	Clinical crown lengthening—hard tissue	751
D4260	Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth bounded spaces per quadrant	1074
D4261	Osseous surgery (including flap entry and closure)—one to three contiguous teeth or tooth bounded spaces per quadrant	890
D4263	Bone replacement graft—each additional site in quadrant	727
D4264	Bone replacement graft—first site in quadrant	555
D4265	Biologic materials to aid in soft and osseous tissue regeneration	550
D4266	Guided tissue regeneration—resorbable barrier, per site	831
D4267	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)	984
D4268	Surgical revision procedure, per tooth	810
D4270	Pedical soft tissue graft procedure	826
D4271	Free soft tissue graft procedure (including donor site surgery)	895
D4273	Subepithelial connective tissue graft procedures, per tooth	1088
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	670
D4275	Soft tissue allograft	969
D4276	Combined connective tissue and double pedicle graft, per tooth	1085
D4320	Provisional splinting—intracoronal	508
D4321	Provisional splinting—extracoronal	466
D4341	Periodontal scaling and root planing—four or more teeth per quadrant	251
D4342	Periodontal scaling and root planing—one to three teeth per quadrant	185
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	183

CDT Code	Description	Maximum Reimbursement
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	140
D4910	Periodontal maintenance	139
D4920	Unscheduled dressing change (by someone other than treating dentist)	100
D4999	Unspecified periodontal procedure, by report	BR
D5110	Complete denture—maxillary	1689
D5120	Complete denture—mandibular	1700
D5130	Immediate denture—maxillary	1831
D5140	Immediate denture—mandibular	1849
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	1350
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	1350
D5213	Maxillary partial denture—cast base framework with resin denture bases (including any conventional clasps, rests and teeth)	1781
D5214	Mandibular partial denture—cast base framework with resin denture bases (including any conventional clasps, rests and teeth)	1780
D5225	Maxillary partial denture—flexible base (including any clasps, rests and teeth)	1566
D5226	Mandibular partial denture—flexible base (including any clasps, rests and teeth)	1552
D5281	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	995
D5410	Adjust complete denture—maxillary	89
D5411	Adjust complete denture—mandibular	88
D5421	Adjust partial denture—maxillary	88
D5422	Adjust partial denture—mandibular	88
D5510	Repair broken complete denture base	208
D5520	Replace missing or broken teeth—complete denture (each tooth)	186
D5610	Repair resin denture base	202
D5620	Repair cast framework	291
D5630	Repair or replace broken clasp	262
D5640	Replace broken teeth—per tooth	184
D5650	Add tooth to existing partial denture	224
D5660	Add clasp to existing partial denture	268
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	735
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	750
D5710	Rebase complete maxillary denture	591
D5711	Rebase complete mandibular denture	585
D5720	Rebase maxillary partial denture	563
D5721	Rebase mandibular partial denture	562
D5730	Reline complete maxillary denture (chairside)	372
D5731	Reline complete mandibular denture (chairside)	369
D5740	Reline maxillary partial denture (chairside)	364
D5741	Reline mandibular partial denture (chairside)	368
D5750	Reline complete maxillary denture (laboratory)	475
D5751	Reline complete mandibular denture (laboratory)	475
D5760	Reline maxillary partial denture (laboratory)	469
D5761	Reline mandibular partial denture (laboratory)	472
D5810	Interim complete denture (maxillary)	848
D5811	Interim complete denture (mandibular)	853
D5820	Interim partial denture (maxillary)	690

CDT Code	Description	Maximum Reimbursement
D5821	Interim partial denture (mandibular)	690
D5850	Tissue conditioning, maxillary	204
D5851	Tissue conditioning, mandibular	205
D5860	Overdenture—complete, by report	2121
D5861	Overdenture—partial, by report	2048
D5862	Precision attachment, by report	700
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	385
D5875	Modification of removable prosthesis following implant surgery	393
D5899	Unspecified removable prosthodontic procedure, by report	BR
D5911	Facial moulage (sectional)	BR
D5912	Facial moulage (complete)	BR
D5913	Nasal prosthesis	BR
D5914	Auricular prosthesis	BR
D5915	Orbital prosthesis	BR
D5916	Ocular prosthesis	BR
D5919	Facial prosthesis	BR
D5923	Ocular prosthesis, interim	BR
D5924	Cranial prosthesis	BR
D5925	Facial augmentation implant prosthesis	BR
D5926	Nasal prosthesis, replacement	BR
D5957	Auricular prosthesis, replacement	BR
D5958	Orbital prosthesis, replacement	BR
D5929	Facial prosthesis, replacement	BR
D5931	Obturator prosthesis, surgical	BR
D5932	Obturator prosthesis, definitive	BR
D5933	Obturator prosthesis, modification	BR
D5934	Mandibular resection prosthesis with guide flange	BR
D5935	Mandibular resection prosthesis without guide flange	BR
D5936	Obturator prosthesis interim	BR
D5937	Trismus appliance (not for TMD treatment)	746
D5951	Feeding aid	844
D5952	Speech aid prosthesis, pediatric	BR
D5953	Speech aid prosthesis, adult	BR
D5954	Palatal augmentation prosthesis	BR
D5955	Palatal lift prosthesis, definitive	BR
D5958	Palatal lift prosthesis, interim	BR
D5959	Palatal lift prosthesis, modification	BR
D5960	Speech aid prosthesis modification	BR
D5982	Surgical stent	450
D5983	Radiation carrier	BR
D5984	Radiation shield	BR
D5985	Radiation cone locator	BR
D5986	Fluoride gel carrier	210
D5987	Commissure splint	BR
D5988	Surgical splint	770
D5991	Topical medicament carrier	226
D5992	Adjust maxillofacial prosthetic appliance, by report	BR
D5993	Maintenance and cleaning of maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	BR
D5999	Unspecified maxillofacial prosthesis, by report	BR
D6190	Radiographic/surgical implant index, by report	375
D6010	Surgical placement of implant body: endosteal implant	2001
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1577
D6040	Surgical placement: eosteal implant	8380
D6050	Surgical placement: transosteal implant	5807
D6100	Implant removal, by report	760
D6055	Connecting bar—implant supported abutment support	2900

CDT Code	Description	Maximum Reimbursement
D6506	Prefabricated abutment—includes placement	789
D6057	Custom abutment—includes placement	952
D6053	Implant/abutment supported removable denture for completely edentulous arch	2790
D6054	Implant/abutment supported removable denture for partially edentulous arch	2751
D6078	Implant/abutment supported fixed denture for completely edentulous arch	5335
D6079	Implant/abutment supported fixed denture for partially edentulous arch	3800
D6058	Abutment supported porcelain/ceramic crown	1479
D6059	Abutment supported porcelain/ceramic crown (high noble metal)	1479
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	1361
D6061	Abutment supported porcelain fused to metal crown (noble metal)	1382
D6062	Abutment supported cast metal crown (high noble metal)	1432
D6063	Abutment supported cast metal crown (predominantly base metal)	1317
D6064	Abutment supported cast metal crown (noble metal)	1366
D6094	Abutment supported crown—(titanium)	1376
D6065	Implant supported porcelain/ceramic crown	1543
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1545
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	1575
D6068	Abutment supported retainer for porcelain/ceramic FPD	1469
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	1474
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	1384
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	1384
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	1451
D6073	Abutment supported retainer for porcelain cast metal FPD (predominantly base metal)	1384
D6074	Abutment supported retainer for cast metal FPD (noble metal)	1384
D6194	Abutment supported retainer crown for FPD (titanium)	1392
D6075	Implant supported retainer for ceramic FPD	1529
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)	1538
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)	1587
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	297
D6090	Repair implant supported prosthesis, by report	742
D6095	Repair implant abutment, by report	731
D6091	Replacement of semi-precious or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	631
D6092	Recent implant/abutment supported crown	160
D6093	Recent implant/abutment supported fixed partial denture	182
D6199	Unspecified implant procedure, by report	BR
D6205	Pontic—indirect resin based composite	988

CDT Code	Description	Maximum Reimbursement
D6210	Pontic—cast high noble metal	1089
D6211	Pontic—cast predominately base metal	998
D6212	Pontic—cast noble metal	1041
D6214	Pontic—titanium	1100
D6240	Pontic—porcelain fused to high noble metal	1100
D6241	Pontic—porcelain fused to predominantly base metal	1024
D6242	Pontic—porcelain fused to noble metal	1051
D6245	Pontic—porcelain/ceramic	1140
D6250	Pontic—resin with high noble metal	1058
D6251	Pontic—resin with predominantly base metal	1049
D6252	Pontic—resin with noble metal	1040
D6253	Provisional pontic	769
D6254	Interim pontic	BR
D6545	Retainer—cast metal for resin bonded fixed prosthesis	852
D6548	Retainer—porcelain/ceramic for resin bonded fixed prosthesis	950
D6600	Inlay—porcelain/ceramic, two surfaces	1000
D6601	Inlay—porcelain/ceramic, three or more surfaces	1052
D6602	Inlay—cast high noble metal, two surfaces	1015
D6603	Inlay—cast high noble metal, three or more surfaces	1050
D6604	Inlay—predominantly base metal, two surfaces	994
D6605	Inlay—predominantly base metal, three or more surfaces	1046
D6606	Inlay—cast noble metal, two surfaces	998
D6607	Inlay—cast noble metal, three or more surfaces	1050
D6624	Inlay—titanium	1080
D6608	Onlay—porcelain/ceramic, two surfaces	1061
D6609	Onlay—porcelain/ceramic, three or more surfaces	1127
D6610	Onlay—cast high noble metal, two surfaces	1074
D6611	Onlay—cast high noble metal, three or more surfaces	1111
D6612	Onlay—predominantly base metal, two surfaces	1038
D6613	Onlay—predominantly base metal, three or more surfaces	1095
D6614	Onlay—cast noble metal, two surfaces	1050
D6615	Onlay—cast noble metal, three or more surfaces	1102
D6634	Onlay—titanium	1125
D6710	Crown—indirect resin based composite	1025
D6720	Crown—resin with high noble metal	1056
D6721	Crown—resin with predominantly base metal	1032
D6722	Crown—resin with noble metal	1050
D6740	Crown—porcelain/ceramic	1146
D6750	Crown—porcelain fused to high noble metal	1107
D6751	Crown—porcelain fused to predominantly base metal	1010
D6752	Crown—porcelain fused to noble metal	1050
D6780	Crown—3/4 cast high noble metal	1075
D6781	Crown—3/4 cast predominantly base metal	1038
D6782	Crown—3/4 cast noble metal	1050
D6783	Crown—3/4 porcelain/ceramic	1100
D6790	Crown—full cast high noble metal	1085
D6791	Crown—full cast predominantly base metal	997
D6792	Crown—full cast noble metal	1040
D6794	Crown—titanium	1059
D6793	Provisional retainer crown	523
D6795	Interim retainer crown	BR
D6920	Connector bar	995
D6930	Recement fixed partial denture	171
D6940	Stress breaker	435

CDT Code	Description	Maximum Reimbursement
D6950	Precision attachment	650
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	433
D6972	Prefabricated post and core in addition to fixed partial denture retainer	344
D6973	Core build up for retainer, including any pins	275
D6975	Coping—metal	700
D6976	Each additional indirectly fabricated post—same tooth	290
D6977	Each additional prefabricated post—same tooth	204
D6980	Fixed partial denture repair, by report	387
D6985	Pediatric partial denture, fixed	915
D6999	Unspecified fixed prosthodontic procedure, by report	BR
D7111	Extraction, coronal remnants—deciduous tooth	135
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	174
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	275
D7220	Removal of impacted tooth—soft tissue	315
D7230	Removal of impacted tooth—partially bony	395
D7240	Removal of impacted tooth—completely bony	484
D7241	Removal of impacted tooth—completely bony, with unusual surgical complications	576
D7250	Surgical removal of residual tooth roots (cutting procedure)	304
D7251	Coronectomy—intentional partial tooth removal	BR
D7260	Oroantral fistula closure	1026
D7261	Primary closure of a sinus perforation	757
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	561
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	746
D7280	Surgical access of an unerupted tooth	482
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	526
D7283	Placement of device to facilitate eruption of impacted tooth	523
D7285	Biopsy of oral tissue—hard (bone, tooth)	437
D7286	Biopsy of oral tissue—soft	320
D7287	Exfoliative cytological sample collection	184
D7288	Brush biopsy—transepithelial sample collection	195
D7290	Surgical repositioning of teeth	528
D7291	Transseptal fibrotomy/surpa crestal fibrotomy, by report	315
D7292	Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap	3300
D7293	Surgical placement: temporary anchorage device requiring surgical flap	2528
D7294	Surgical placement: temporary anchorage device without surgical flap	1619
D7295	Harvest of bone for use in autogenous grafting procedure	BR
D7310	Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	295
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	309
D7320	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	443

CDT Code	Description	Maximum Reimbursement
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	437
D7340	Vestibuloplasty—ridge extension (secondary epithelialization)	1164
D7350	Vestibuloplasty—ridge extension (including soft tissue graft, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	2467
D7410	Excision of benign lesion up to 1.25 cm	415
D7411	Excision of benign lesion greater than 1.25 cm	630
D7412	Excision of benign lesion, complicated	850
D7413	Excision of malignant lesion greater than 1.25 cm	751
D7414	Excision of malignant lesion up to 1.25 cm	1132
D7415	Excision of malignant lesion, complicated	1253
D7465	Destruction of lesion(s) by physical or chemical method, by report	459
D7440	Excision of malignant tumor—lesion diameter up to 1.25cm	720
D7441	Excision of malignant tumor—lesion greater than 1.25cm	1224
D7450	Removal of benign odontogenic cyst or tumor—lesion diameter up to 1.25cm	588
D7451	Removal of benign odontogenic cyst or tumor—lesion diameter greater than 1.25cm	782
D7460	Removal of benign nonodontogenic cyst or tumor—lesion diameter greater than 1.25cm	573
D7461	Removal of benign nonodontogenic cyst or tumor—lesion diameter up to 1.25cm	874
D7470	Removal of lateral exostosis (maxilla or mandible)	653
D7472	Removal of torus palatinus	859
D7473	Removal of torus mandibularis	761
D7485	Surgical reduction of osseous tuberosity	755
D7490	Radial resection of maxilla or mandible	8006
D7510	Incision and drainage of abscess—extraoral soft tissue	236
D7511	Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces)	367
D7520	Incision and drainage of abscess—extraoral tissue	169
D7521	Incision and drainage of abscess—extraoral tissue—complicated (includes drainage of multiple fascial spaces)	630
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	364
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	708
D7550	Partial osteotomy/osteostrectomy for removal of non-vital bone	600
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	1308
D7610	Maxilla—open reduction (teeth immobilized, if present)	4464
D7620	Maxilla—closed reduction (teeth immobilized, if present)	3450
D7630	Mandible—open reduction (teeth immobilized, if present)	4576
D7640	Mandible—closed reduction (teeth immobilized, if present)	3483
D7650	Malar and/or zygomatic arch—open reduction	3924
D7660	Malar and/or zygomatic arch—closed reduction	3277
D7670	Alveolus closed reduction may include stabilization of teeth	1746
D7671	Alveolus open reduction may include stabilization of teeth	1298

CDT Code	Description	Maximum Reimbursement
D7680	Facial bones—complicated reduction with fixation and multiple surgical approaches	6555
D7710	Maxilla open reduction	4568
D7720	Maxilla—closed reduction	3462
D7730	Mandible—open reduction	4826
D7740	Mandible—closed reduction	3636
D7750	Malar and/or zygomatic arch—open reduction	4230
D7760	Malar and/or zygomatic arch—closed reduction	6044
D7770	Alveolus open reduction stabilization of teeth	2794
D7771	Alveolus closed reduction stabilization of teeth	1958
D7780	Facial bones—complicated reduction with fixation and multiple surgical approaches	8587
D7810	Open reduction of dislocation	4271
D7820	Closed reduction of dislocation	644
D7830	Manipulation under anesthesia	990
D7840	Condylectomy	5466
D7850	Surgical discectomy, with/without implant	5356
D7852	Disc repair	5541
D7854	Synovectomy	5278
D7856	Myotomy	3505
D7858	Joint reconstruction	BR
D7860	Arthrotomy	BR
D7865	Arthroplasty	BR
D7870	Arthrocentesis	562
D7871	Non-arthroscopic lysis and lavage	BR
D7872	Arthroscopy—diagnosis, with or without biopsy	BR
D7873	Arthroscopy—surgical: lavage and lysis of adhesions	BR
D7874	Arthroscopy—surgical: disc repositioning and stabilization	BR
D7875	Arthroscopy—surgical: synovectomy	BR
D7876	Arthroscopy—surgical: discectomy	BR
D7877	Arthroscopy—surgical: debridement	BR
D7880	Occlusal orthotic device, by report	990
D7899	Unspecified TMD therapy, by report	BR
D7910	Suture of recent small wounds up to 5 cm	300
D7911	Complicated suture—up to 5 cm	486
D7912	Complicated suture—greater than 5 cm	792
D7920	Skin graft (identify defect covered, location and type of graft)	2677
D7940	Osteoplasty—for orthognathic deformities	4123
D7941	Osteotomy—mandibular rami	9139
D7943	Osteotomy—mandibular rami with bone graft; includes obtaining the graft	8623
D9744	Osteotomy—segmented or subapical	7006
D7945	Osteotomy—body of mandible	6983
D7946	LeFort I (maxilla—total)	8251
D7947	LeFort I (maxilla—segmented)	8393
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft	9586
D7949	LeFort II of LeFort III—with bone graft	11832
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or maxilla—autogenous or nonautogenous, by report	3116
D7951	Sinus augmentation with bone or bone substitutes	3200
D7953	Bone replacement graft for ridge preservation—per site	800
D7955	Repair of maxillofacial soft and/or hard tissue defect	3807
D7960	Frenulectomy—also known as frenectomy or frenotomy—separate procedure not incidental to another procedure	450
D7936	Frenuloplasty	499
D7970	Excision of hyperplastic tissue—per arch	517

CDT Code	Description	Maximum Reimbursement
D7971	Excision of pericoronal gingiva	258
D7972	Surgical reduction of fibrous tuberosity	796
D7980	Sialolithotomy	843
D7981	Excision of salivary gland, by report	BR
D7982	Sialodochoplasty	1749
D7983	Closure of salivary fistula	1528
D7990	Emergency tracheotomy	1482
D7991	Coronoidectomy	4056
D7995	Synthetic graft—mandible or facial bones, by report	BR
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report	BR
D7997	Appliance removal (not by dentist who place appliance), includes removal of archbar	350
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	2572
D7999	Unspecified oral surgery procedure, by report	BR
D8010	Limited orthodontic treatment of the primary dentition	2149
D8020	Limited orthodontic treatment of the transitional dentition	2459
D8030	Limited orthodontic treatment of the adolescent dentition	2901
D8040	Limited orthodontic treatment of the adult dentition	3237
D8050	Interceptive orthodontic treatment of the primary dentition	2590
D8060	Interceptive orthodontic treatment of the transitional dentition	2796
D8070	Comprehensive orthodontic treatment of the transitional dentition	5200
D8080	Comprehensive orthodontic treatment of the adolescent dentition	5250
D8090	Comprehensive orthodontic treatment of the adult dentition	5308
D8210	Removable appliance therapy	861
D8220	Fixed appliance therapy	968
D8660	Pre-orthodontic treatment visit	384
D8670	Periodic orthodontic treatment visit (as part of contract)	263
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers(s))	532
D8690	Orthodontic treatment (alternative billing to a contract fee)	283
D8691	Repair of orthodontic appliance	210
D8692	Replacement of lost or broken retainer	330
D8693	Rebonding or recementing; and/or repair as require, of fixed retainers	356
D8999	Unspecified orthodontic procedure, by report	BR
D9110	Palliative (emergency) treatment of dental pain—minor procedure	126
D9120	Fixed partial denture sectioning	250
D9210	Local anesthesia not in conjunction with operative or surgical procedures	74
D9211	Regional block anesthesia	96
D9212	Trigeminal division block anesthesia	272
D9215	Local anesthesia in conjunction with operative or surgical procedures	65

CDT Code	Description	Maximum Reimbursement
D9220	Deep sedation/general anesthesia—first 30 minutes	392
D9221	Deep sedation/general anesthesia—each additional 15 minutes	174
D9230	Inhalation of nitrous oxide / anxiolysis analgesia	79
D9241	Intravenous conscious sedation/analgesia—first 30 minutes	416
D9242	Intravenous conscious sedation/analgesia—each additional 15 minutes	169
D9248	Non-intravenous conscious sedation	325
D9310	Consultation—diagnostic services provided by dentist or physician other than requesting dentist or physician	129
D9410	House/extended care facility call	246
D9420	Hospital or ambulatory surgery center call	299
D9430	Office visit for observation (during regularly scheduled hours)—no other services performed	76
D9440	Office visit after regularly scheduled hours	179
D9450	Case presentation, detailed and extensive treatment planning	145
D9610	Therapeutic parental drug, single administration	111
D9612	Therapeutic parental drug, two or more administrations, different medications	193
D9630	Other drugs and/or medicaments, by report	49
D9910	Application of desensitizing medicament	63
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	79
D9920	Behavior management, by report	160
D9930	Treatment of complications (post-surgical)—unusual circumstances, by report	132
D9940	Occlusal guard, by report	600
D9941	Fabrication of athletic mouthguard	254
D9942	Repair and/or reline of occlusal guard	250
D9950	Occlusion analysis—mounted case	344
D9951	Occlusal adjustment—limited	182
D9952	Occlusal adjustment—complete	687
D9970	Enamel microabrasion	202
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	176
D9972	External bleaching—per arch	328
D9973	External bleaching—per tooth	231
D9974	Internal bleaching—per tooth	291
D9999	Unspecified adjunctive procedure, by report	BR

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:1167 (September 1993), amended LR 20:1298 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR 39:2043 (July 2013), LR 40:379 (February 2014), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:

Public Comments

Inquiries concerning the Emergency Rule may be sent to Patrick Robinson, OWC-Administration, 1001 North Twenty-Third Street, Baton Rouge, LA 70802.

Curt Eysink
Executive Director

1509#089

Rules

RULE

Office of the Governor Board of Certified Public Accountants

Maintenance of Competency and Continuing Professional Education (CPE) (LAC 46:XIX.Chapter 13)

In accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., and pursuant to the authority vested in the state Board of Certified Public Accountants of Louisiana (board) by the Louisiana Accountancy Act, R.S. 37:71 et seq., the board has amended its rules governing continuing professional education (CPE) of certified public accountants (CPAs), LAC 46:XIX.1301-1311. The amendments are set forth below.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XIX. Certified Public Accountants

Chapter 13. Maintenance of Competency; Continuing Professional Education (CPE)

§1301. Basic Requirements

A. Each certificate holder shall participate in a minimum of 20 hours of continuing professional education (CPE) annually, and at least 80 hours of continuing professional education (CPE) within a rolling two-calendar-year period defined as the compliance period in §1301.F.1. Prior to January 1, 2016, each certificate holder shall participate in at least 120 hours of continuing professional education (CPE) every three years.

1. Accounting and Auditing Requirements. Certificate holders who participate in one or more attest engagements during the calendar year shall complete at least 20 percent of the required hours in the subject area described in §1307.A.1 in fulfilling the above requirements. Certificate holders participating in attest engagements include those responsible for conducting substantial portions of the procedures and those responsible for planning, directing, or reporting on attest engagements. Persons who "plan, direct, and report" generally include the in-charge accountant, the supervisor or manager, and the firm owner who signs or authorizes someone to sign the attest engagement report on behalf of the firm.

2. Professional Ethics Requirements. All certificate holders who are required to complete CPE shall complete a course in professional ethics, the contents of which must have been pre-approved by the board.

3. Personal Development Limitations. Personal development hours in excess of 20 hours during a calendar year will be disallowed and cannot be used for CPE credit. Prior to January 1, 2016, personal development hours cannot exceed 50 percent of the total qualifying CPE.

4. Reporting Method. Each certificate holder shall, when applying for certificate renewal, report CPE information in the manner approved by the board.

5. Reporting. The CPE must be reported to the board no later than January 31 after the end of each December 31 calendar year. Prior to February 1, 2016, the CPE must be reported to the board no later than January 31 after the end of the December 31 compliance period.

B. ...

C. An individual who held a license on June 17, 1999, or was issued a certificate on or after June 18, 1999, who applies to reinstate a license after having allowed such license or certificate to lapse must present proof, documented in a form satisfactory to the board, that he has satisfied the requirements for continuing professional education for the preceding compliance period as specified by §1301.F.

D. Extensions/Waivers. The board may at its sole discretion grant extensions of time or waivers to complete the continuing education requirements for hardship situations or for medical reasons. The hardship or incapacity must be sufficiently documented (for example, by appropriate third parties, or by medical providers in the case of a medical issue) in order for the board to consider granting an extension or waiver.

E. Effective Date for Compliance of Initial Licenses and Reinstatements

1. Any individual who obtains an initial certificate or who reinstates his license will not be required to obtain current continuing professional education until the following full calendar year, which will also start the compliance period for that individual as defined in §1301.F.

2. Prior to January 1, 2016, as to any individual who obtains an initial certificate or who reinstates his license, the effective date of these requirements shall be January 1 of the first calendar year of the then current CPE compliance period. The hours required are reduced pro rata for the then current CPE compliance period, as follows.

a. An individual initially licensed or reinstating a license during the first calendar year of the then current CPE compliance period shall have an 80 hour requirement.

b. An individual initially licensed or reinstating a license during the second calendar year of the then current CPE compliance period shall have a 40 hour requirement.

c. An individual initially licensed or reinstating a license during the third calendar year of the then current CPE compliance period shall not have any hours required.

F. Compliance Period

1. The compliance period for continuing professional education is defined as the two-year period starting January 1, 2016 and ending December 31, 2017. Subsequent compliance periods shall be defined as a rolling two-year period ending on December 31 of each year thereafter (i.e. two-year period ending on December 31, 2018 including years 2017 and 2018, then two-year period ending on December 31, 2019 including years 2018 and 2019, and so forth.)

2. Prior to January 1, 2016, the first compliance period for continuing professional education was the three-year period ended December 31, 1982, and subsequent

compliance periods shall end on December 31 each third year thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Certified Public Accountants, LR 6:4 (January 1980), amended LR 9:2081 (April 1983), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:614 (August 1989), LR 23:1116 (September 1997), LR 26:1976 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 32:2249 (December 2006), LR 41:1664 (September 2015).

§1303. Standards for Program

A. - A.6. ...

B. Program Presentation

1. - 4. ...

5. There must be a reasonable method for the CPE sponsor to monitor group programs in order to verify attendance for the duration of the program.

6. In cases of group programs that are presented online, or via the Internet, there must be a process to monitor and verify participation. Monitoring must be of sufficient frequency and lack predictability in order to verify that participants are engaged for the duration of the program. If polling questions are used as the monitoring process, at least three polling questions must be used per CPE credit hour.

7. In cases where a small group is allowed to participate in an online program, and the sponsor allows one participant to facilitate by logging in and/or to submit questions on behalf of the group of participants, the attendance must be documented and verified by the small group facilitator or administrator in order to verify participation for the duration of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Certified Public Accountants, LR 6:5 (January 1980), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:614 (August 1989), LR 23:1116 (September 1997), LR 26:1976 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 41:1665 (September 2015).

§1305. Programs which Qualify

A. ...

B. Continuing education programs qualify if they meet the above standards and if:

1. ...

2. group programs are at least 50 minutes in length and self-study programs are at least 25 minutes in length; and

B.3. - E. ...

F. If a certificate holder claims credit on a subject related to his practice or employment as a CPA for an education or training program which does not comply with all applicable CPE requirements, he must retain all relevant information regarding the program in order to provide documentation, in the event that the board requests it, that demonstrates that the program is equivalent to one which meets these CPE requirements. (Examples of such programs are as follows: a specialized or technical program offered through an industry sponsor; a course or training program offered by a governmental agency to various interested

groups; and, a program primarily directed to another licensed profession which has its own types of continuing education.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Adopted by the Department of Commerce, Board of Certified Public Accountants, January 1974, promulgated LR 6:5 (January 1980), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:614 (August 1989), LR 17:1068 (November 1991), LR 23:1116 (September 1997), LR 26:1977 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 34:2561 (December 2008), LR 41:1665 (September 2015).

§1307. Subjects which Qualify

A. The following general subject matters are acceptable as long as they contribute to the professional knowledge and professional competence of the individual certificate holder and are relevant to the services rendered or to be rendered by the individual certificate holder in public practice, industry, academia or government.

1. Accounting and Auditing. This field of study includes accounting and financial reporting subjects, pronouncements of authoritative accounting principles issued by the standard-setting bodies and any other related subject generally classified within the accounting discipline. It also includes auditing subjects related to the examination of financial statements, operations systems, and programs; the review of internal and management controls; the reporting on the results of audit findings; compilations, reviews, and preparations. It also includes assurance services that relate to standards for attest engagements.

A.2. - B.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Adopted by the Department of Commerce, Board of Certified Public Accountants, January 1974, promulgated as LR 6:5 (January 1980), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:615 (August 1989), LR 23:1117 (September 1997), LR 26:1977 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 41:1665 (September 2015).

§1309. Credit Hours Granted

A. Class Hours

1. ...

2. Continuing education credit will be given with a minimum of 50 minutes constituting one hour. For continuous conferences, conventions and other programs when individual segments are less than 50 minutes, the sum of the segments will be considered equal to one total program. Under the following conditions, one-half credits (equal to 25 minutes each) may be permitted:

a. for group programs, after at least one 50-minute hour credit has been earned, half credits (of 25 minutes) are permitted;

b. for self-study programs, half credits (of 25 minutes) are permitted.

3. When the total minutes of the total program are greater than 50, but not equally divisible by 50, the CPE credits granted must be rounded down to the nearest one-half credit. (For example, CPE with segments totaling 140 minutes would be granted two and one-half CPE credits.)

4. Credit courses at accredited universities or colleges shall earn 15 hours of continuing education for each semester hour of credit. A quarter hour credit shall equal 10 hours.

5. Continuing education credit allowable for noncredit short courses at accredited universities or colleges shall equal time in class in accordance with §1309.A.2.

B. Self-Study Program. The amount of credit to be allowed for correspondence and formal self-study programs is to be recommended by the program developer, and based on one of the methods identified in the statement on standards for continuing professional education (CPE) programs. Credit will be allowed in the period in which the course is completed as indicated on the certificate of completion.

1. Interactive self-study programs shall receive CPE credit provided the course satisfies the following criteria:

a. - b. ...

2. Self-study courses developed by or registered with the AICPA, NASBA, or a state society of CPAs are acceptable as continuing education.

3. CPE program developers shall keep appropriate records of how the recommended amount of credit for self-study programs was determined.

4. A recorded group program is considered as a group program only when a qualified instructor is available for interaction.

5. A group program that is recorded or archived by the sponsor for future presentations which does not include a qualified instructor available for interaction is considered a self-study program and must satisfy all the self-study requirements in order to be claimed as continuing education.

C. Service as Lecturer or Speaker

1. - 2. ...

3. The maximum credit allowed for teaching and preparation cannot exceed 20 hours of continuing professional education earned in a calendar year; excess hours in a calendar year cannot be used for CPE credit. Prior to January 1, 2016, the maximum credit for teaching and preparation, cannot exceed 50 percent of the three-year requirement under these rules.

D. Writing of Published Articles, Books, CPE Programs, etc.

1. Credit for writing published articles, books, and CPE programs will be awarded in an amount determined by a board representative provided the writing contributes to the professional competence of the certificate holder. The board and author may choose to mutually approve a third party representative. CPAs requesting a third party representative will be charged a fee; the fee is to be negotiated and agreed upon prior to the engagement.

2. The maximum credit allowed for preparation of articles and books cannot exceed 10 hours of continuing professional education earned in a calendar year; excess hours in a calendar year cannot be used for CPE credit. Prior to January 1, 2016, the maximum credit for preparation of articles and books cannot exceed 25 percent of the three-year requirement under these rules.

D.3. - E.2. ...

F. Completion of Board-Approved Exams

1. CPE credit may be allowed for the successful completion of exams as may be approved by the board from time-to-time.

2. Credit will be awarded one time only at a rate of 5 times the length of each exam passed (or exam section passed). The maximum credit allowed for the successful completion of board approved exams will be limited to 20 hours of continuing professional education earned in a calendar year; excess hours in a calendar year cannot be used for CPE credit. Prior to January 1, 2016, credit will be limited to 50 percent of the three-year requirement.

G. Board Approved Research and Other Programs

1. Credit may be granted from time to time on completion of specific research or programs as approved by the board.

2. Credits may be awarded upon demonstration of achieving an increased level of competency that contributes directly to the professional knowledge and competence of an individual certificate holder.

3. Evidence of completion of such programs or research must be provided in the manner required by the board for evaluation and approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Adopted by the Department of Commerce, Board of Certified Public Accountants, January 1974, promulgated LR 6:5 (January 1980), amended LR 11:757 (August 1985), LR 13:13 (January 1987), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:615 (August 1989), LR 17:1068 (November 1991), LR 23:1117 (September 1997), LR 26:1978 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 34:2562 (December 2008), LR 41:1665 (September 2015).

§1311. Maintenance of Records and Control

A. Participants in CPE programs shall retain the documentation of their participation in CPE programs for a period of five years after the end of the calendar year in which the program is completed. Participants in CPE programs shall also retain advance materials, which should include the requirements set forth in §1303.B.1, and other promotional material which reflects the content of a course and the name of the instructor(s) in the event the participant is requested by the board to substantiate the course content.

B. Acceptable evidence of completion includes, but is not limited to, the following:

1. for group programs, a certificate of attendance or other verification supplied by the sponsor which includes:

- a. ...
- b. name and signature of a sponsor representative;
- c. participant's name;
- d. location of course;
- e. title and/or description of content;
- f. dates attended; and
- g. the qualifying hours recommended by the course sponsor;

2. for individual study programs, a certificate supplied by the sponsor after satisfactory completion of a workbook,

an examination, or an interactive course that confirms the name of the sponsor, name and signature of a sponsor representative, participant's name, the title and/or description of the course contents, the date of completion and the qualifying hours recommended by the course sponsor;

B.3. - C. ...

D. Each sponsoring organization shall maintain records of programs sponsored which shall show:

1. that the programs were developed and presented in accordance with the standards set forth in §§1303-1305. If a program is developed by one organization and sponsored by another, the sponsoring organization shall not be responsible for program development standards and related record maintenance if:

a. it has reviewed the program and has no reason to believe that program development standards have not been met; and

b. it has on record certification by the developing organization that the program development standards have been met and that the developing organization will maintain the required records relative thereto.

E. The CPE program sponsor shall maintain records and information required under these rules for a minimum of five years after the end of the calendar year in which the CPE course was completed. Such information may be kept in electronic or paper form.

F. Records required under this rule shall be maintained for five years and shall be made available to the board or its designee(s) for inspection at the board's request.

G. Failure of a CPE program sponsor to comply with the CPE standards shall be cause for the board to deny credit for courses offered by the CPE sponsor until such time as the CPE sponsor can demonstrate to the board that the compliance standards are being met.

H. The board specifically reserves the right to approve or disapprove credit for all continuing education under this state board's rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:71 et seq.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Certified Public Accountants, LR 6:6 (January 1980), amended by the Department of Economic Development, Board of Certified Public Accountants, LR 15:615 (August 1989), LR 23:1118 (September 1997), LR 26:1979 (September 2000), amended by the Office of the Governor, Board of Certified Public Accountants, LR 41:1666 (September 2015).

Darla M. Saux, CPA, CGMA
Executive Director

1509#034

RULE

Office of the Governor Committee on Parole

Ameliorative Penalty Consideration (LAC 22:XI.Chapter 8)

In accordance with the provisions of the Administrative Procedure Act (R.S.49:950), the Committee on Parole has amended LAC 22:XI.802, repealed §807, and adopted §809.

This rulemaking provides for notification to the victim and prosecuting district attorney that an application has been docketed for ameliorative penalty consideration by the Committee on Parole, provides for input by the victim and prosecuting district attorney into the ameliorative penalty consideration process. In LAC 22:XI.809, the Rule provides that upon receipt of a recommendation for ameliorative review consideration from the Committee on Parole, the procedure for such consideration shall follow the procedures outlined in LAC 22:V.211.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part XI. Committee on Parole

Chapter 8. Ameliorative Penalty Consideration

§802. Victim and District Attorney Notification

[Formerly §807]

A. The victim and district attorney shall be invited to provide written input into the ameliorative penalty consideration process.

B. The committee shall ensure victims registered with the Crime Victims Services Bureau of the department receive written notification of the date and time an offender is docketed for review by a parole panel. A copy of the letter to the victim shall also be sent to the prosecuting district attorney. Such notice shall be made no less than 30 days prior to the scheduled docket date for administrative review.

C. In any case where there is no registered victim, the prosecuting district attorney shall be provided notice as set forth above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:574.2 et seq., and R.S. 15:540 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Pardons, Committee on Parole, LR 41:46 (January 2015), amended by the Office of the Governor, Committee on Parole, LR 41:1667 (September 2015).

§807. Victim Notification

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:574.2 et seq., and R.S. 15:540 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Pardons, Committee on Parole, LR 41:46 (January 2015), repealed by the Office of the Governor, Committee on Parole, LR 41:1667 (September 2015).

§809. Consideration by the Board of Pardons

A. Upon receipt of a recommendation for ameliorative review consideration from the Committee on Parole, the Board of Pardons shall notify the offender in writing of the requirement to place advertisement in the official journal of the parish where the offense occurred. The ad must state: "I, (applicant's name), (DOC number), have applied for ameliorative penalty consideration for my conviction of (crime). If you have any comments, contact the Board of Pardons (225) 342-5421."

B. The applicant shall provide the board office with proof of advertisement within 60 days from the date of notice that a hearing has been granted.

C. After receipt of the clemency investigation from the appropriate probation and parole district and any other documents requested by the board, the board shall set the matter for public hearing.

D. The procedure for hearings conducted for the purpose of ameliorative penalty consideration shall follow the

procedures outlined in LAC 22:V.211 and board policy 02-209, "Hearings before the Board of Pardons."

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:574.2 et seq., and R.S. 15:540 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Committee on Parole, LR 41:1667 (September 2015).

Sheryl M. Ranatza
Board Chair

1509#018

RULE

Office of the Governor Crime Victims Reparations Board

Compensation to Victims (LAC 22:XIII.303 and 503)

In accordance with the provisions of R.S. 49:950 et seq., which is the Administrative Procedure Act, and R.S. 46:1801 et seq., which is the Crime Victims Reparations Act, the Crime Victims Reparations Board hereby promulgates rules and regulations regarding the awarding of compensation to applicants.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part XIII. Crime Victims Reparations Board

Chapter 3. Eligibility and Application Process

§303. Application Process

A. Claimant Responsibility

1. ...

2. Applications:

a. must be signed and dated by the victim/claimant. If the victim is a minor, the parent or guardian is the claimant and must sign. If the victim is deceased, the person responsible for the expenses can be the claimant and must sign the application;

b. victims of sexual assault may assign their right to collect medical expenses associated with the sexual assault to a hospital/health care facility; however, the cost of the forensic medical examination is not reimbursable by the board as provided in §503.M.2. The hospital/health care facility may then apply for reparations for these expenses.

A.3 - D.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), amended by the Office of the Governor, Crime Victims Reparations Board, LR 41:1668 (September 2015).

Chapter 5. Awards

§503. Limits on Awards

A. - L.1. ...

M. Crime Scene Evidence

1. - 1.c. ...

2. Medical Examination of Sexual Assault Victims

a. Costs of the forensic medical examination are the responsibility of the coroner or his designee as provided by R.S. 13:5713(F) and are not reimbursable by the Crime Victims Reparations Board (CVR Board) under this Section. All other expenses related to victims of sexual assault are

reimbursable by the board subject to the maximum permitted by LAN and the provisions of the Crime Victims Reparations Act and its administrative rules.

b. In instances where the sexual assault victim assigns his or her rights to collect reparations for reimbursable medical expenses beyond those associated with the forensic medical examination to the hospital/health care facility, the hospital/health care facility must submit the following items directly to the CVR Board within one year of the date of service in order to receive reimbursement:

i. victim of sexual assault assignment of rights form, signed by the victim;

ii. hospital/health care CVR application;

iii. itemized bill for services rendered.

c. The sexual assault victim may submit these expenses to his or her private insurance or other third-party payor. If these expenses are paid by insurance or other third-party payor, the hospital/health care facility may file an application with the CVR Board for any unreimbursed expenses.

d. Nothing in this Section shall preclude a sexual assault victim or claimant from filing a regular or emergency application for additional benefits.

3. A forensic medical examination for a victim of sexual assault is considered an expense associated with the collection and securing of crime scene evidence. Payment for this examination by the parish governing authority is mandated by state law. All other expenses related to these crimes are eligible for reimbursement by the board, subject to the provisions of the Crime Victims Reparations Act and its administrative rules.

N. - O.3.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), LR 24:328 (February 1998), LR 25:26 (January 1999), LR 26:1019 (May 2000), LR 29:577 (April 2003), LR 31:1330 (June 2005), LR 32:242 (February 2006), LR 35:65 (January 2009), LR:37:1605 (June 2011), LR 39:1042 (April 2013), LR 41:1668 (September 2015).

Lamarr Davis
Chairman

1509#045

RULE

Office of the Governor Division of Administration Office of State Procurement

Procurement (LAC 34:V.901, 2503, 2506,
2521, 2534, 2545-2549, 2587-2596, and 3103)

Editor's Note: The following Rule is being repromulgated to make technical corrections. The original Rule can be viewed in the December 20, 2014 *Louisiana Register* on pages 2544-2547.

In accordance with provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Office of the Governor, Division of Administration, Office of State Purchasing, has amended Chapters 9, 25, and 31, Procurement, of LAC 34:V.

Senate Bill 480 was signed by Governor Bobby Jindal and became Act 864 of the 2014 Regular Legislative Session. Act 864, which becomes effective January 1, 2015, amends and reenacts R.S.3:4(B)(1)(b), and chapter 17 of subtitle III of title 39 of the *Louisiana Revised Statutes* of 1950, to be comprised of R.S. 39:1551 through 1755, and repeals chapter 16 of subtitle III of title 39 of the *Louisiana Revised Statutes* of 1950, comprised of R.S. 39:1481 through 1526. The amended and reenacted statutes effectively combine Louisiana's procurement of services provisions (formerly chapter 16 of title 39) into the *Louisiana Procurement Code* (chapter 17 of title 39) and places all authority, duties and responsibilities under a new central purchasing agency identified as the Office of State Procurement.

The following amendments are necessary in order to bring current into compliance with Act 864.

Title 34

GOVERNMENT CONTRACTS, PROCUREMENT AND PROPERTY CONTROL

Part V. Louisiana Procurement Code

Chapter 9. Sole Source Procurement

§901. Application

[Formerly LAC 34:I.901]

A. These provisions shall apply to all sole source procurement unless emergency conditions exist as defined in Chapter 11 (Emergency Procurement) of these regulations.

B. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1581.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 8:331 (July 1982), amended LR 21:566 (June 1995), repromulgated LR 40:1356 (July 2014), amended LR 40: 2546 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1669 (September 2015).

Chapter 25. Procurement of Professional, Personal, Consulting, Social Services, and Energy Efficiency Contracts

Subchapter A. General Provisions

§2503. Definitions and Classes of Contractual Services [Formerly LAC 34:V.103]

A. ...

1. Personal Services

2. *Professional Service*—for contracts with a total amount of compensation of \$50,000 or more, the definition of "professional service" shall be limited to lawyers, doctors, dentists, veterinarians, architects, engineers, landscape architects, accountants, claims adjusters, and any other profession that may be added by regulations adopted by the Office of State Procurement of the Division of Administration.

3. Consulting Service

4. ...

5. Social Service

6a. - 7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:181 (April 1981), amended LR 8:591 (November 1982), LR 10:455 (June 1984), LR 11:1067 (November 1985), LR

13:652 (November 1987), LR 17:264 (March 1991), LR 20:542 (May 1994), repromulgated LR 40:2556 (December 2014), amended LR 40:2544 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1669 (September 2015).

§2506. Contracts for \$10,000 or Less [Formerly LAC 34:V.106]

A. - B. ...

C. The using agency shall submit a quarterly report to the Office of State Procurement. This report shall contain a listing of all small purchase contracts to include: the name of contractor, amount of contract, specific nature of services rendered, date of contract, and total dollar amount of all small purchase contracts entered into by the using agency for that quarter. If no such contracts have been entered into during this period, a report shall still be submitted notifying the Office of State Procurement of same.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:179 (April 1981), amended LR 8:591 (November 1982), LR 10:455 (June 1984), LR 11:1068 (November 1985), LR 17:265 (March 1991), amended by the Office of State Purchasing, LR 40:2545 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2561 (December 2014), amended LR 40:2545 (December 2014), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1282 (July 2015), repromulgated LR 41:1669 (September 2015).

§2521. Contractual Review Process [Formerly LAC 34:V.121]

A. Contracts arriving in the Office of State Procurement will be date stamped and logged in. Contracts should be submitted prior to their effective dates and no contract shall be approved which has been submitted 60 days after its effective date unless written justification is provided by the using agency and approval granted by the director of contractual review or his designee. All submittals will be required to have a cover letter attached thereto.

B. - E.10.b.ii. ...

F. Each contract over \$5,000 submitted for approval shall be accompanied by a certification letter as described in R.S. 39:1497, signed by the using agency's representative.

G. - L. ...

M. A performance evaluation for every personal, professional, consulting or social services contract shall be done by the using agency in accordance with R.S. 39:1500. This performance evaluation shall be retained by the using agency for all small purchase contracts approved under delegated authority. For all other contracts this performance evaluation shall be submitted to the Office of State Procurement within 120 days after the termination of the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:182 (April 1981), amended LR 8:592 (November 1982), LR 10:456 (June 1984), LR 11:1069 (November 1985), LR 13:87 (February 1987), LR 13:653 (November 1987), LR 15:81 (February 1989), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2562

(December 2014), amended LR 40:2545 (December 2014), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:671 (April 2015), repromulgated LR 41:1669 (September 2015).

§2534. Cost Reimbursement Contracts
[Formerly LAC 34:V.134]

A. - A.2. ...

3. the contract shall require the contractor to obtain a contract compliance audit of expenditures charged to the contract. This compliance audit shall be performed by a certified public accountant or the Louisiana Legislative Auditor's Office. A contract compliance audit must include an examination of reimbursed expenditures to determine if they are in accord with contract terms, not reimbursed by any other source, and in accord with any guidelines set by the using agency or other relevant authority. This examination shall be conducted in accordance with generally accepted auditing and sampling procedures, including the *Government Auditing Standards*.

a. - d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B) and 39:1521.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 15:82 (February 1989), amended by the Office of State Purchasing, LR 40:2545 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2565 (December 2014), amended LR 40:2545 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1670 (September 2015).

Subchapter B. Contracts Let Via a Request for Proposals Process

§2545. Request for Proposals
[Formerly LAC 34:V.145]

A. - A.7.c. ...

8. - 12. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 4:495 (December 1978), amended LR 7:180 (April 1981), LR 8:594 (November 1982), LR 10:459 (June 1984), LR 11:1072 (November 1985), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2567 (December 2014), amended LR 40:2545 (December 2014), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1283 (July 2015), repromulgated LR 41:1670 (September 2015).

Subchapter B. Contracts Let Via a Request for Proposals Process

§2547. Contracts for Data Processing Consulting Services [Formerly LAC 34:V.147]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 10:460 (June 1984), amended LR 11:1073 (November 1985), LR 13:655 (November 1987), repealed by the Office of State Purchasing, LR 40:2545 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1670 (September 2015).

Subchapter C. Contracts for Data Processing Consulting Services in an Amount Greater than \$100,000

§2549. Procurement Support Team
[Formerly LAC 34:V.149]

A. Unless a procurement support team is formed in accordance with R.S.39:200(I), a procurement support team shall be formed in accordance with the procedures defined herein for every contract for the procurement of data processing consulting services in an amount greater than \$100,000. The formation of a procurement support team shall be accomplished by the Office of State Procurement and shall include one or more representatives from each of the following: the Office of State Procurement, the Attorney General's Office; the using agency initiating the procurement action; and the Legislative Fiscal Office. The procurement support team shall submit a recommendation to the Director of the Office of State Procurement concerning the final contract. Where a procurement support team is formed in accordance with R.S. 39:200(I), the requirements of this Section may be met by including a representative from the Attorney General's Office.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 10:460 (June 1984), amended LR 11:1073 (November 1985), amended by the Office of State Purchasing, LR 40:2545 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2568 (December 2014), amended LR 40:2545 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1670 (September 2015).

Subchapter D. Revised Statutes

§2587. Revised Statutes
[Formerly LAC 34:V.187]

A. These regulations shall be read and interpreted jointly with R.S. 39:1551-1755.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 4:497 (December 1978), amended LR 7:183 (April 1981), LR 8:596 (November 1982), LR 10:461 (June 1984), LR 11:1074 (November 1985), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:2570 (December 2014), amended LR 40:2546 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1670 (September 2015).

Subchapter E. Appendices

§2589. Appendix A—Sample Contract
[Formerly LAC 34:V.189]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:183 (April 1981), amended LR 8:596 (November

1982), LR 10:461 (June 1984), LR 11:1074 (November 1985), LR 15:83 (February 1989), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1670 (September 2015).

§2591. Appendix B—Sample Certification
[Formerly LAC 34:V.191]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:184 (April 1981), amended LR 8:596 (November 1982), LR 10:462 (June 1984), LR 11:1075 (November 1985), LR 15:84 (February 1989), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

§2592. Appendix C—Suggested Checklist for Review of Personal, Professional, Consulting and Social Services Contracts [Formerly LAC 34:V.193]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:184 (April 1981), amended LR 8:596 (November 1982), LR 10:462 (June 1984) LR 11:1075 (November 1985), LR 13:655 (November 1987), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

§2593. Appendix D—Agency Transmittal Letter
[Formerly LAC 34:V.195]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:185 (April 1981), amended LR 8:597 (November 1982), LR 10:463 (June 1984), LR 11:1076 (November 1985), LR 15:84 (February 1989), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

§2594. Appendix E—Quarterly Report on Small Purchase Contracts
[Formerly LAC 34:V.197]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 8:597 (November 1982), amended LR 10:463 (June 1984), LR 11:1076 (November 1985), LR 15:84 (February 1989), LR 17:266 (March 1991), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

§2595. Appendix F—Performance Evaluation
[Formerly LAC 34:V.199]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 10:463 (June 1984), amended LR 11:1076 (November

1985), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

§2596. Appendix G—Sample Auditor's Opinion for Contract Compliance Audits
[Formerly LAC 34:V.201]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 15:84 (February 1989), repealed by the Office of State Purchasing, LR 40:2546 (December 2014), repealed by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

Chapter 31. Protests and Appeals, Bidder Responsibility, Suspension and Debarment of Bidders, Contract Controversies

§3103. Application
[Formerly LAC 34:I.3103]

A. The following rules shall only apply to hearings held by boards of higher education and institutions under their jurisdiction in accordance with §§601, 1671, 1672, and 1673 of Title 39 of the *Louisiana Revised Statutes*, unless the institution is operating under a pilot procurement code in accordance with R.S. 17:3139.5(5)(c)(i) which has adopted rules or procedures that supersede these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1581.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of the Commissioner, LR 9:210 (April 1983), amended LR 23:67 (January 1997), repromulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 40:1366 (July 2014), amended, LR 40:2546 (December 2014), repromulgated by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:1671 (September 2015).

Jan B. Cassidy
Assistant Commissioner

1509#044

RULE

Office of the Governor
Division of Administration
Racing Commission

Controlled Medication (LAC 35:I.1725)

The Louisiana State Racing Commission hereby amends the following Rule. The amendment in conjunction with LAC 35:I.1505 and LAC 35:I.1787 changes the amount of medication allowed to be given for the therapeutic and/or nonsteroidal and/or anti-inflammatory medications listed in the *List of Controlled Therapeutic Medications* published by the Association of Racing Commissioners International, Inc. Louisiana is a member of the Association of Racing Commissioners International, Inc., and therefore has a vote on including medications from this list. Currently, there are 26 medications on this list. These medications consist of category 3, 4, or 5 medication, drug, or substance as defined and listed by the Association of Racing Commissioners

International, Inc., Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances*. The Rule memorializes the current Rule which provides that detection of any category 1 or 2 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc. Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances* constitutes a violation.

This Rule was formally adopted by the commission at the August 24, 2015 commission meeting. This Rule will be effective September 20, 2015, but will include a transitional period where the new drug thresholds will not trigger a positive test call until November 15, 2015. During this transitional period, trainers will be provided notification of what will be violations of the new threshold levels set forth in the ARCI medication schedule, but will not be penalized for such violations until November 15, 2015.

However, any test that would have been a Rule violation prior to this Rule change will still be considered a violation during the transition period.

Title 35

HORSE RACING

Part I. General Provisions

Chapter 17. Corrupt and Prohibited Practices

§1725. Controlled Medication

A. Controlled medications are permitted in Louisiana as set forth in the list of controlled therapeutic medications published by the Association of Racing Commissioners International, Inc. and shall only be administered as therein prescribed and regulated at the threshold levels set forth in said list.

B. The controlled therapeutic medications list as published by the Association of Racing Commissioners International, Inc., shall be maintained on the commission website and at the domicile office and be made available to the public upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:148.

HISTORICAL NOTE: Adopted by the Racing Commission in 1971, promulgated by the Department of Commerce, Racing Commission, LR 2:449 (December 1976), amended LR 3:45 (January 1977), LR 4:287 (August 1978), amended by the Office of the Governor, Division of Administration, Racing Commission, LR 41:1672 (September 2015).

Charles A. Gardiner, III
Executive Director

1509#022

RULE

Office of the Governor Division of Administration Racing Commission

Pre-Race Testing (LAC 35:I.1787)

The Louisiana State Racing Commission has amended the following Rule. The amendment in conjunction with LAC 35:I.1505 and LAC 35:I.1725 changes the amount of medication allowed to be given for the therapeutic and/or

nonsteroidal and/or anti-inflammatory medications listed in the *List of Controlled Therapeutic Medications* published by the Association of Racing Commissioners International, Inc. Louisiana is a member of the Association of Racing Commissioners International, Inc., and therefore has a vote on including medications from this list. Currently, there are 26 medications on this list. These medications consist of category 3, 4, or 5 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc., Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances*. The Rule memorializes the current Rule which provides that detection of any category 1 or 2 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc. Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances* constitutes a violation.

This Rule was formally adopted by the commission at the August 24, 2015 commission meeting. This Rule will be effective September 20, 2015, but will include a transitional period where the new drug thresholds will not trigger a positive test call until November 15, 2015. During this transitional period, trainers will be provided notification of what will be violations of the new threshold levels set forth in the ARCI medication schedule, but will not be penalized for such violations until November 15, 2015.

However, any test that would have been a Rule violation prior to this Rule change will still be considered a violation during the transition period.

Title 35

HORSE RACING

Part I. General Provisions

Chapter 17. Corrupt and Prohibited Practices

§1787. Pre-Race Testing

A - G. ...

H. Whenever pre-race laboratory test reports indicate the presence of a prohibited medication or drug in the sample taken from a horse scheduled to race, particularly, but not limited to specific maximum by quantitative determination of 2.0 micrograms phenylbutazone per milliliter of blood, stewards shall scratch the horse from the race. On the first offense a penalty of not less than \$100, nor more than \$200, shall be assessed the trainer. Upon second or multiple offenses for positive tests, the stewards shall take whatever action they deem appropriate, consistent with law and the *Rules of Racing*.

I. - L. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:141 and R.S. 4:148.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Racing Commission, LR 8:140 (March 1982), amended LR 12:419 (July 1986), amended by the Office of the Governor, Division of Administration, Racing Commission, LR 41:1672 (September 2015).

Charles A. Gardiner, III
Executive Director

1509#023

RULE
Office of the Governor
Division of Administration
Racing Commission

Therapeutic and/or Nonsteroidal
and/or Anti-Inflammatory Medication
(LAC 35:I.1505)

The Louisiana State Racing Commission has amended the following Rule. The amendment in conjunction with LAC 35:I.1725 and LAC 35:I.1787 changes the amount of medication allowed to be given for the therapeutic and/or nonsteroidal and/or anti-inflammatory medications listed in the *List of Controlled Therapeutic Medications* published by the Association of Racing Commissioners International, Inc. Louisiana is a member of the Association of Racing Commissioners International, Inc., and therefore has a vote on including medications from this list. Currently, there are 26 medications on this list. These medications consist of category 3, 4, or 5 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc., Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances*. The Rule memorializes the current Rule which provides that detection of any category 1 or 2 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc. Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances* constitutes a violation.

This Rule was formally adopted by the commission at the August 24, 2015 commission meeting. This Rule will be effective September 20, 2015, but will include a transitional period where the new drug thresholds will not trigger a positive test call until November 15, 2015. During this transitional period, trainers will be provided notification of what will be violations of the new threshold levels set forth in the ARCI medication schedule, but will not be penalized for such violations until November 15, 2015.

However, any test that would have been a Rule violation prior to this Rule change will still be considered a violation during the transition period.

Title 35
HORSE RACING
Part I. General Provisions
Chapter 15. Permitted Medication
§1505. Therapeutic and/or Nonsteroidal and/or Anti-
Inflammatory Medication

A. No nonsteroidal and/or anti-inflammatory medication and/or therapeutic medication of any kind may be administered to or used on a horse in training and eligible to be raced at a race meeting in this state except by a licensed veterinarian or a licensed trainer, or under his or her personal order; provided, however, that any such medication given hypodermically may only be administered by a licensed veterinarian. The nonsteroidal, anti-inflammatory medications and/or therapeutic medication of any kind shall only be allowed to be administered as is set forth in Chapter 17, Section 1721 and Section 1725. All other category 3, 4

and 5 medications as listed by the Association of Racing Commissioners International, Inc., Drug Testing and Quality Assurance Program's uniform classification guidelines for foreign substances may not be administered within 24 hours of a race in which a horse is entered to race.

B. ...

C. Detection of any category 1 or 2 medication, drug, or substance as defined and listed by the Association of Racing Commissioners International, Inc. Drug Testing and Quality Assurance Program's *Uniform Classification Guidelines for Foreign Substances* constitutes a violation.

AUTHORITYNOTE: Promulgated in accordance with R.S. 4:141 and R.S. 4:142.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Racing Commission, LR 9:547 (August 1983), amended by the Office of the Governor, Division of Administration, Racing Commission, LR 37:1393 (May 2011), LR 38:1408 (June 2012), LR 39:1281 (May 2013), LR 41:1673 (September 2015).

Charles A. Gardiner, III
Executive Director

1509#021

RULE
Office of the Governor
Division of Administration
Racing Commission

Timing of Entering Next Claiming Race (LAC 35:X1.9905)

The Louisiana State Racing Commission has amended the following Rule. The amended Rule requires that the claimed horse shall not enter in starter, optional or claiming races for 30 days after being claimed in a race in which the determining eligibility price is less than 25 percent more than the price at which the horse was claimed, wherein the Rule previously allowed a horse to be claimed and enter in an optional or claiming races for 30 days after being claimed in a race in which the determining eligibility price is less than the price at which the horse was claimed.

Title 35
HORSE RACING
Part XI. Claiming Rules and Engagements
Chapter 99. Claiming Rule
§9905. Timing of Entering Next Claiming Race

A. Except as otherwise provided herein, a claimed horse shall not enter in starter, optional or claiming races for 30 days after being claimed in a race in which the determining eligibility price is less than 25 percent more than the price at which the horse was claimed. The day claimed shall not count, but the following calendar day shall be the first day and the horse shall be entitled to enter whenever necessary so the horse may start on the thirty-first day following the claim for any claiming price. This provision shall not apply to starter handicaps in which the weight to be carried is assigned by the handicapper. A similar rule in other states will be recognized and enforced.

AUTHORITYNOTE: Promulgated in accordance with R.S. 4:141, R.S. 4:142 and R.S. 4:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Racing Commission, LR 30:1476 (July 2004), amended LR 33:2422 (November 2007), LR 41:1673 (September 2015).

Charles A. Gardiner III
Executive Director

1509#024

RULE

Department of Health and Hospitals Board of Examiners in Dietetics and Nutrition

Registered Dietitians/Nutritionists
(LAC 46:LXIX.Chapters 1-5)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:3085, the Board of Examiners in Dietetics and Nutrition has amended regulations to make technical changes and clarifications, conform with recent Centers for Medicare and Medicaid Services rulings, and provide that military applicants currently registered by the Commission on Dietetic Registration (CDR) are deemed qualified for licensure.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXIX. Registered Dietitians/Nutritionists

Chapter 1. Dietitians/Nutritionists

§101. Definitions

A. As used in this Chapter, the following terms and phrases, which have not already been defined in the Practice Act, and R.S. 37:3081-3094 are defined as following.

Academy—the Academy of Nutrition and Dietetics (AND), formerly the American Dietetic Association (ADA). Accreditation Council for Education in Nutrition and Dietetics (ACEND) is the AND's accrediting agency for education programs preparing students for careers as dietetic or nutrition practitioners. It is recognized by the Board as the approved credentialing evaluation agency for dietitians/nutritionists.

Act—Louisiana Dietetic/Nutrition Practice Act of 1987.

Applicant—any person who has applied to the board for a regular license or provisional license to use the title dietitian or nutritionist and to engage in the practice of dietetics/nutrition in the state of Louisiana.

Application—a written request directed to and received by the board, upon forms supplied by the board, for a license or provisional license to practice dietetics/nutrition in the state of Louisiana, together with all information, certificates, documents, and other materials required by the board.

Commission on Dietetic Registration (CDR)—the Commission on Dietetic Registration that is a member of the National Commission for Health Certifying Agencies and is responsible for registering and/or credentialing dietetic practitioners.

Degree—a degree of baccalaureate or higher received from a college or university granted by a U.S. regionally accredited college or university, or foreign equivalent with a major course of study in human nutrition, food and nutrition, dietetics, or food systems management.

* * *

Dietetic Practice, Nutrition Counseling, and Medical Nutrition Therapy—terms that may be used interchangeably.

Dietetic Practitioner—dietitian/nutritionist licensee practicing dietetics and nutrition according to R.S. 37:3081 to R.S. 37:3093, of the Louisiana Dietetic/Nutrition Practice Act.

* * *

Examination—satisfactory completion of an examination in order to be licensed is required by the Dietetic/Nutrition Practice Act. The board recognizes the registration examination administered by CDR and the passing score set by CDR as the board's examination.

Incidental to the Practice of their Profession—as specified in that profession's practice act or licensure law in the state of Louisiana as interpreted by that profession's regulatory board or agency as referred to in R.S. 37:3093.

Licensed Dietitian/Nutritionist—a person licensed under R.S. 37:3081-3093. The terms "dietitian", "dietician", and "nutritionist" may be used interchangeably.

Louisiana Association—Louisiana Dietetic Association (LDA) dba Louisiana Academy of Nutrition and Dietetics (LAND), an affiliate of the Academy of Nutrition and Dietetics (AND).

Nutrition Care Process—as defined by the AND, as nutrition assessment, nutrition diagnosis, nutrition intervention/plan of care, and nutrition monitoring and evaluation.

Nutrition Counseling (also referred to as *medical nutrition therapy (MNT)*)—a therapeutic approach to treating medical conditions and their associated symptoms via the use of a specifically tailored diet devised and monitored by a licensed and/or registered dietitian/nutritionist. Nutrition counseling provides individualized guidance on appropriate food and nutrient intake for those with special metabolic needs, taking into consideration health, cultural, socioeconomic, functional and psychological facts from the nutrition assessment. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size or composition of meals; to modify food textures; and in extreme instances, to change the route of administration.

Nutrition Education—imparts information about food and nutrients, diet lifestyle factors, community nutrition resources and services to the general public in order to facilitate and promote healthy eating and physical activity.

Nutritional Assessment—the evaluation of the nutritional needs of individuals and groups based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs including enteral and parenteral nutrition regardless of setting, including but not limited to ambulatory settings, hospitals, nursing homes and other extended care facilities.

Provisionally Licensed Dietitian/Nutritionist—a person provisionally licensed under the Louisiana Dietitian/Nutritionist Act.

Registered Dietitian/Nutritionist—a person registered by the CDR.

Scope of Dietetic/Nutrition Practice—the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, management, behavioral, and social sciences to achieve and maintain

client health through the provision of nutrition care services, which shall include:

a. assessing the nutritional needs of individuals and groups based upon appropriate biochemical, anthropometric, physical, and dietary data to determine nutrient needs and recommend appropriate nutritional intake including enteral and parenteral nutrition;

b. establishing priorities, goals and objectives that meet nutritional needs and are consistent with available resources;

c. providing nutrition counseling by advising and assisting individuals or groups on appropriate nutritional intake by integrating information from the nutritional assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status;

d. developing, implementing, and managing nutrition care systems; and

e. evaluating, making changes in, and maintaining standards of quality in food and nutrition care services.

Title—any use of the titles “dietitian”, “dietician”, or “nutritionist”, or any abbreviation or facsimile cannot be used unless the person is licensed in accordance with the provisions of the Louisiana Dietetic/Nutrition Practice Act. The board may cause to issue a writ of injunction enjoining any person from violating this provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 25:1094 (June 1999), LR 37:2152 (July 2011), LR 40:302 (February 2014), LR 41:1674 (September 2015).

§103. Qualifications for Licensure

A. Regular Licensure

1. Academic Requirements. Persons applying for licensure must have earned a baccalaureate or post-baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent and meet minimum academic requirements approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the AND. Applicant must present verification statement from an ACEND accredited program dated no later than five years after completion of the academic requirements.

2. Professional Experience. An applicant for licensure shall submit to the board evidence of having successfully completed a planned continuous supervised practice program approved by the board of not less than 900 hours under the supervision of a registered dietitian or a licensed dietitian/nutritionist. The board has designated a supervised practice program accredited by ACEND of the AND as the board-approved program of planned supervised practice program.

3. Examination for Licensure. An applicant for licensure shall pass an examination approved by the board. The board recognizes the registration examination for dietitians administered by the CDR as the board-approved exam.

4. Continuing Education Requirements. The board recognizes the CDR professional development portfolio

(PDP) system as fulfilling the continuing education requirement for license renewal. Requirements for continuing education are considered to be met if a current CDR card is provided by the licensee to the board annually.

5. Applicants who are currently registered by CDR are deemed to meet the academic, professional experience, examination, and continuing education requirements for licensure.

6. Applicants who hold a doctoral degree granted prior to July 1, 1988, in addition to a baccalaureate or higher degree from a regionally accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, food systems management or biochemistry shall have met the requirements for licensure, as long as the person’s application was approved by the board, and license and fees have been renewed as prescribed by the board.

B. Provisional Licensure

1. Applicants who are not registered by CDR but who present evidence to the board of successful completion of the academic and professional experience requirements of §103.A.1-2 for licensure no later than five years after completion of the academic and professional experience requirements may apply for a provisional license.

2. A provisional license may be issued to such a person before he/she has successfully completed the licensure examination prescribed by the board.

3. A provisional license may be issued for a period not exceeding one year and may be renewed annually for a period not to exceed five years upon payment of a fee and documentation of evidence that the provisional license holder is practicing only under the supervision of a licensed dietitian/nutritionist and also provides evidence of at least 15 hours of continuing education per license year.

C. Licensing of Qualified Military Commissioned Applicants and Spouses of Military Personnel

1. A military-trained dietitian/nutritionist is eligible for licensure as a dietitian/nutritionist as provided for in Subsections A-B of this Section provided the applicant:

a. has completed a military program of training in dietetics and nutrition and has been awarded a military occupational specialty or similar official designation as a dietitian/nutritionist with qualifications which are substantially equivalent to or exceed the requirements of the applicable license (including the provisional license authorized by R.S. 37:3087) which is the subject of the application;

b. has performed dietetics and nutritionist services in active practice at a level that is substantially equivalent to or exceeds the requirements of the applicable license which is the subject of the application;

c. has not been disciplined in any jurisdiction for an act which would have constituted grounds for refusal, suspension, or revocation of a license to practice dietetics/nutrition in this state at the time the act was committed; and

d. has not received a dishonorable discharge from military service.

2. A military-trained dietitian/nutritionist, who has not been awarded a military occupational specialty or other official designation as a dietitian/nutritionist, who nevertheless holds a current license as a dietitian or

nutritionist in another state, District of Columbia or territory of the United States, which jurisdiction's requirements are substantially equivalent to or exceed the requirements for the license for which he or she is applying, is eligible for licensure, by reciprocity or endorsement pursuant to §105 provided the applicant:

a. has not been disciplined in any jurisdiction for an act which would have constituted grounds for refusal, suspension, or revocation of a license to practice dietetics/nutrition in this state at the time the act was committed; and

b. has not received a dishonorable discharge from military service.

3. A spouse of a member of the active-duty military forces or a spouse of a former member of the military forces who has not received a dishonorable discharge and who holds a current license as a dietitian or nutritionist in another state, District of Columbia or territory of the United States, which jurisdiction's requirements are substantially equivalent to or exceed the requirements of Subsections A-B of this Section for the applicable license for which he or she is applying, is eligible for licensure by reciprocity or endorsement pursuant to §105 provided the applicant:

a. has not been disciplined in any jurisdiction for an act which would have constituted grounds for refusal, suspension, or revocation of a license to practice dietetics/nutrition in this state at the time the act was committed; and

b. is in good standing and has not been disciplined by the agency that issued the license.

4. The procedures governing the applications of military-trained applicants and applicants who are spouses of military personnel, including the issuance and duration of temporary practice permits and priority processing of applications, are provided for in §109.J.

5. Military applicants who are currently registered by CDR are deemed qualified for licensure and may provide verification of CDR registration to the board in lieu of options listed above if this will expedite the licensure process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 37:2152 (July 2011), LR 40:302 (February 2014), LR 41:1675 (September 2015).

§107. Licensing of Dietitians/Nutritionists Trained in a Foreign Country

A. Any person who has been trained as a dietitian/nutritionist in a foreign country and who desires to be licensed under the act may make application if the individual:

1. holds a degree from an education program which has been evaluated by an approved credentialing evaluation agency, ACEND as equivalent to the baccalaureate or higher degree conferred by universities or colleges regionally accredited by the council on post-secondary accreditation and the U.S. Department of Education and meets equivalent academic requirements;

a. submits to the board any diploma or other document required for a foreign graduate applicant. A

diploma or other document which is not in the English language must be accompanied by a certified translation thereof in English by an approved credentials evaluation service;

2. submits documentary evidence to the board that he or she has completed a course of professional experience as described in §103.A.2 of this Part;

3. successfully completed the prescribed examination for licensure;

4. demonstrates satisfactory proof of proficiency in the English language;

5. applicants who are currently registered by CDR are deemed to meet the academic, professional experience, examination, and continuing education requirements for licensure;

6. applications for licensure shall be upon the form and in the manner prescribed by the board, accompanied by the appropriate fees;

7. at the time of making such application, the applicant shall pay the fee prescribed by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 41:1676 (September 2015).

§109. Application for Licensure and/or Provisional Licensure

A. Application for license or provisional license must be upon the form and in the manner and fee prescribed by the board.

B. - E. ...

F. The board will send a notice to an applicant who does not fully complete the application, listing the additional materials required.

G. - H. ...

I. An applicant who meets all the requirements of R.S. 37:3086 or 3087 and who has worked more than 30 days as a dietitian/nutritionist in the state of Louisiana and who has not otherwise violated any part of R.S. 37:3081-3093 or its rules and regulations, may be offered the following options in the form of a consent agreement and order to resolve the situation:

1. applicant is reprimanded for practicing as a dietitian and/or nutritionist in Louisiana without a license;

2. - 3. ...

4. the consent agreement and order shall not be considered disciplinary action, but will be published by LBEDN.

J. - J.5. ...

6. Military applicants and/or military spouse applicants who are currently registered by the CDR are deemed to meet all requirements for licensure. Such applicants may provide evidence of CDR registration in lieu of other documentation listed above if this is more expedient to the licensure process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR

14:435 (July 1988), amended LR 37:2153 (July 2011), LR 40:302 (February 2014), LR 41:1676 (September 2015).

§111. Issuance and Renewal of Licensure

A. The board recognizes two distinct types of licensure. Applicants may be issued a regular license or a provisional license based on compliance with requirements stated in the Louisiana Dietitian/Nutritionist Practice Act and described in these regulations. The board shall issue a license to any person who meets the requirements upon payment of the license fee prescribed.

B. Regular License. The board may issue a regular license to any dietitian/nutritionist who qualifies in accordance with the requirements of R.S. 37:3086(A), (B) or (C), and who practices in Louisiana, whether resident or nonresident, unless otherwise exempted as stated in R.S. 37:3093 of the Dietetic/Nutritionist Practice Act and these regulations. The board will send each applicant whose credentials have been approved a license.

C. Provisional License

1. A provisional license shall permit the holder to practice only under the direct supervision of a licensed dietitian/nutritionist. The board may issue a provisional license to any dietitian/nutritionist who meets the following requirements:

a. shall have earned a baccalaureate or post-baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent, and meet minimum academic requirements accredited by ACEND;

b. the board may issue a provisional license to a person before he has taken the examination prescribed by the board;

c. a provisional license may be issued for a period not exceeding one year and may be renewed annually for a period not to exceed five consecutive years upon payment of an annual fee and presentation of evidence satisfactory to the board that applicant is meeting the supervision requirements and the continuing education requirement of at least 15 hours of continuing education per license year.

D. Supervision of Provisional Licensed Dietitian

1. The purpose of this Section is to set out the nature and scope of the supervision provided for provisional licensed dietitians/nutritionists.

2. To meet initial licensure and license renewal requirements, a provisionally licensed dietitian/nutritionist shall practice under the direct supervision of a licensed dietitian/nutritionist. *Direct supervision* is defined as a licensed dietitian/nutritionist providing sufficient guidance and direction to enable a provisional licensed dietitian/nutritionist to perform competently. The supervising licensee needs to be readily available in person or by telecommunications and will review the provisionally licensed dietitian/nutritionist's work quarterly and submit to the board annually on a form provided by the board a written report that the applicant is in the process of meeting the experience requirements in anticipation of taking the examination.

E. Upgrading a Provisional License

1. In order to upgrade to a regular license, the provisionally licensed dietitian/nutritionist shall submit to the board a written request, proof of successful completion of the registration examination administered by CDR or

evidence of current registration with CDR, as well as the upgrade fee.

2. When the upgrade occurs, the licensee shall become subject to the renewal requirements for a regular licensed dietitian/nutritionist.

F. License Certificates

1. The board shall prepare and provide to each licensee a license certificate and license identification card.

2. Official license certificates shall be signed by the board chairman, vice-chairman, and secretary-treasurer and be affixed with the seal of the board.

3. Any license certificate and license identification card issued by the board remains the property of the board and must be surrendered to the board on demand.

4. The license certificate must be displayed in an appropriate and public manner as follows:

a. shall be displayed in the primary place of employment of the licensee; or

b. in the absence of a primary place of employment or when the licensee is employed at multiple locations, the licensee shall carry a current, board issued license identification card.

5. Neither the licensee nor anyone else shall display a photocopy of a license certificate or carry a photocopy of a license identification card in lieu of the original license certificate or license identification card.

6. Neither the licensee nor anyone else shall make any alteration on a license certificate or license identification card issued by the board.

7. The board shall replace a lost, damaged or destroyed license certificate or ID card upon receipt of a written request from the licensee and payment of the license replacement fee.

8. The board, upon receipt of a written request, shall reissue a license certificate and/or license identification card in the case of name changes. Requests shall be accompanied by payment of the license replacement fee and appropriate documentation reflecting the change.

G. Abandonment of Application. An applicant shall be deemed to have abandoned the application if the requirements for licensure are not completed within one year of the date on which the application is received. An application submitted subsequently to an abandoned application shall be treated as a new application.

H. Disapproved Applications. The board shall disapprove the application if the applicant:

1. has not completed the requirements of §103 of these regulations including academic and experience requirements;

2. has failed to pass the examination prescribed by the board;

3. has failed to remit any applicable fees;

4. has failed to comply with requests for supporting documentation prescribed by the board;

5. has deliberately presented false information on application documents required by the board to verify the applicant's qualifications for licensure;

6. has been convicted of a felony.

I. Renewal of Licensure

1. At least 30 days prior to the expiration date of the license, the licensee shall be sent written notice of the

amount of renewal fee due, which must be returned with the required fee.

2. Licensee's application for renewal must be postmarked on or prior to the expiration date in order to avoid the late renewal fee. Failure to receive renewal notice shall not be justification for late or non-renewal.

3. The board shall not renew the license of a person who is in violation of the act, or board rules at the time of application for renewal.

4. Licensed Dietitian/Nutritionist

a. Licenses will expire annually on June 30.

b. Applicants receiving an initial license in the last quarter of the fiscal year (April, May, June) are not required to renew or provide proof of continuing education until the following licensing one year period.

5. Provisional License

a. Licenses will expire annually on June 30.

b. Applicants receiving an initial license in the last quarter of the fiscal year (April, May, June) will not be required to renew or provide proof of continuing education until the following one year licensing period.

6. Continuing Education Requirement for Renewing License

a. For renewal of a regular dietitian/nutritionist license, licensees must submit proof of holding current CDR registration. The board recognizes the CDR PDP system as fulfilling the continuing education requirement for licensure renewal.

b. For renewal of provisional license, provisional licensees must submit proof of at least 15 hours of continuing education per license year.

7. Renewal license identification cards and/or renewal validation documents shall be furnished to each licensee who meets all renewal requirements by the expiration date.

8. The board may provide for the late renewal of a license upon the payment of a late fee within 60 days of the expiration date, July 1 through August 31.

a. If the license has been expired for 60 days or less, the license may be renewed by returning the license renewal form with all appropriate fees and documentation to the board, postmarked on or before the end of the 60-day grace period.

9. A person whose license has expired may not use the title of dietitian or nutritionist or facsimile or present or imply that he or she has the title of "licensed dietitian/nutritionist" or "provisional licensed dietitian/nutritionist" or any abbreviation or facsimile of these titles. Additionally, the person with an expired license may not continue to engage in the practice of dietetics and/or nutrition until the expired license has been renewed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January, 1984); amended by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:436 (July, 1988), LR 26:2613 (November 2000), LR 37:2153 (July 2011), LR 41:1677 (September 2015).

§112. Gratuitous Service during a Declared Public Health Emergency

A. - B. ...

C. A licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist not licensed in Louisiana, whose

licenses and CDR registrations are current and unrestricted in another jurisdiction of the United States, may gratuitously provide dietetic/nutrition services if:

C.1. - D. ...

E. All interested licensed dietitian/nutritionists or provisional licensed dietitian/nutritionists shall submit a copy of their respective current and unrestricted licenses, or CDR registrations issued in other jurisdictions of the United States and photographic identification, as well as other requested information, to the Louisiana Board of Examiners in Dietetics and Nutrition for registration with this agency prior to gratuitously providing dietetic/nutrition services in Louisiana.

F. Should a qualified licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist registered with the board thereafter fail to comply with any requirement or condition established by this Rule, the board may terminate his or her board registration upon notice and hearing.

G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 37:2153 (July 2011), amended LR 41:1678 (September 2015).

§113. Code of Ethics for Professional Conduct

A. Licensees under the Act shall perform their professional duties using the code of ethics adopted by the board.

B. The board has adopted the following American Dietetic Association/Commission on Dietetic Registration:

1. *Code of Ethics for the Profession of Dietetics and Process for Consideration of Ethics Issues* as published: Am Diet Assoc. 2009;109 (8):1461-1467.

PRINCIPLES OF ETHICS

Fundamental Principles

1. The dietetics practitioner conducts himself/herself with honesty, integrity, and fairness.

2. The dietetics practitioner supports and promotes high standards of professional practice. The dietetics practitioner accepts the obligation to protect clients, the public, and the profession by upholding the Code of Ethics for the Profession of Dietetics and by reporting perceived violations of the Code through the processes established by ADA and its credentialing agency, CDR.

Responsibilities to the Public

3. The dietetics practitioner considers the health, safety, and welfare of the public at all times.

The dietetics practitioner will report inappropriate behavior or treatment of a client by another dietetics practitioner or other professionals.

4. The dietetics practitioner complies with all laws and regulations applicable or related to the profession or to the practitioner's ethical obligations as described in this Code.

a. The dietetics practitioner must not be convicted of a crime under the laws of the United States, whether a felony or a misdemeanor, an essential element of which is dishonesty.

b. The dietetics practitioner must not be disciplined by a state for conduct that would violate one or more of these principles.

c. The dietetics practitioner must not commit an act of misfeasance or malfeasance that is directly related to the practice of the profession as determined by a court of competent jurisdiction, a licensing board, or an agency of a governmental body.

5. The dietetics practitioner provides professional services with objectivity and with respect for the unique needs and values of individuals.

- a. The dietetics practitioner does not, in professional practice, discriminate against others on the basis of race, ethnicity, creed, religion, disability, gender, age, gender identity, sexual orientation, national origin, economic status, or any other legally protected category.
 - b. The dietetics practitioner provides services in a manner that is sensitive to cultural differences.
 - c. The dietetics practitioner does not engage in sexual harassment in connection with professional practice.
6. The dietetics practitioner does not engage in false or misleading practices or communications.
- a. The dietetics practitioner does not engage in false or deceptive advertising of his or her services.
 - b. The dietetics practitioner promotes or endorses specific goods or products only in a manner that is not false and misleading.
 - c. The dietetics practitioner provides accurate and truthful information in communicating with the public.
7. The dietetics practitioner withdraws from professional practice when unable to fulfill his or her professional duties and responsibilities to clients and others.
- a. The dietetics practitioner withdraws from practice when he/she has engaged in abuse of a substance such that it could affect his or her practice.
 - b. The dietetics practitioner ceases practice when he or she has been adjudged by a court to be mentally incompetent.
 - c. The dietetics practitioner will not engage in practice when he or she has a condition that substantially impairs his or her ability to provide effective service to others.

Responsibilities to Clients

8. The dietetics practitioner recognizes and exercises professional judgment within the limits of his or her qualifications and collaborates with others, seeks counsel, or makes referrals as appropriate.
9. The dietetics practitioner treats clients and patients with respect and consideration.
- a. The dietetics practitioner provides sufficient information to enable clients and others to make their own informed decisions.
 - b. The dietetics practitioner respects the client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.
10. The dietetics practitioner protects confidential information and makes full disclosure about any limitations on his or her ability to guarantee full confidentiality.
11. The dietetics practitioner, in dealing with and providing services to clients and others, complies with the same principles set forth above in "Responsibilities to the Public" (Principles #3-7).

Responsibilities to the Profession

12. The dietetics practitioner practices dietetics based on evidence-based principles and current information.
13. The dietetics practitioner presents reliable and substantiated information and interprets controversial information without personal bias, recognizing that legitimate differences of opinion exist.
14. The dietetics practitioner assumes a life-long responsibility and accountability for personal competence in practice, consistent with accepted professional standards, continually striving to increase professional knowledge and skills and to apply them in practice.
15. The dietetics practitioner is alert to the occurrence of a real or potential conflict of interest and takes appropriate action whenever a conflict arises.
- a. The dietetics practitioner makes full disclosure of any real or perceived conflict of interest.
 - b. When a conflict of interest cannot be resolved by disclosure, the dietetics practitioner takes such other action as may be necessary to eliminate the conflict, including recusal from an office, position, or practice situation.
16. The dietetics practitioner permits the use of his or her name for the purpose of certifying that dietetics services have

been rendered only if he or she has provided or supervised the provision of those services.

17. The dietetics practitioner accurately presents professional qualifications and credentials.

- a. The dietetics practitioner, in seeking, maintaining, and using credentials provided by CDR, provides accurate information and complies with all requirements imposed by CDR. The dietetics practitioner uses CDR-awarded credentials ("RD" or "Registered Dietitian"; "DTR" or "Dietetic Technician, Registered"; "CS" or "Certified Specialist"; and "FADA" or "Fellow of the American Dietetic Association") only when the credential is current and authorized by CDR.
- b. The dietetics practitioner does not aid any other person in violating any CDR requirements, or in representing himself or herself as CDR-credentialed when he or she is not.

18. The dietetics practitioner does not invite, accept, or offer gifts, monetary incentives, or other considerations that affect or reasonably give an appearance of affecting his/her professional judgment.

Clarification of Principle:

- a. Whether a gift, incentive, or other item of consideration shall be viewed to affect, or give the appearance of affecting, a dietetics practitioner's professional judgment is dependent on all factors relating to the transaction, including the amount or value of the consideration, the likelihood that the practitioner's judgment will or is intended to be affected, the position held by the practitioner, and whether the consideration is offered or generally available to persons other than the practitioner.
- b. It shall not be a violation of this principle for a dietetics practitioner to accept compensation as a consultant or employee or as part of a research grant or corporate sponsorship program, provided the relationship is openly disclosed and the practitioner acts with integrity in performing the services or responsibilities.
- c. This principle shall not preclude a dietetics practitioner from accepting gifts of nominal value, attendance at educational programs, meals in connection with educational exchanges of information, free samples of products, or similar items, as long as such items are not offered in exchange for or with the expectation of, and do not result in, conduct or services that are contrary to the practitioner's professional judgment.
- d. The test for appearance of impropriety is whether the conduct would create in reasonable minds a perception that the dietetics practitioner's ability to carry out professional responsibilities with integrity, impartiality, and competence is impaired.

Responsibilities to Colleagues and Other Professionals

19. The dietetics practitioner demonstrates respect for the values, rights, knowledge, and skills of colleagues and other professionals.
- a. The dietetics practitioner does not engage in dishonest, misleading, or inappropriate business practices that demonstrate a disregard for the rights or interests of others.
 - b. The dietetics practitioner provides objective evaluations of performance for employees and coworkers, candidates for employment, students, professional association memberships, awards, or scholarships, making all reasonable efforts to avoid bias in the professional evaluation of others.

C. All licensees shall be responsible for reporting any and all alleged misrepresentation or violation of the AND/CDR code of ethics and/or board rules to the board.

D. A failure to adhere to the above code of ethics, constitutes unprofessional conduct and a violation of lawful rules and regulations adopted by the board and further constitutes grounds for disciplinary action specified in R.S.

37:3090 of the Dietitian/Nutritionist Practice Act and these rules and regulations and also constitutes grounds for a denial of licensure or a renewal of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary LR 12:12 (January 1984, repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 25:1095 (June 1999), LR 41:1678 (September 2015).

§115. Denial, Suspension or Revocation of License

A. - B. ...

C. A suspended license shall be subject to expiration and may be renewed as provided in this section, but such renewal shall not entitle the licensee, while the license remains suspended and until he or she is reinstated, to engage in the practice of dietetics and/or nutrition, or in any other conduct or activity in violation of the order of judgment by which the license was suspended. If a license is revoked on disciplinary grounds and is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee and any late fee that may be applicable.

D. Disciplinary Options for Licensees Available to the Board. In accordance with R.S. 37:3085, R.S. 37:3088, and R.S. 37:3090, the following disciplinary options are available to the board.

1. - 4. ...

5. Censure. The board makes an official statement of censure concerning the individual.

6. ...

7. Restitution. Requirement imposed upon the licensee that he or she makes financial or other restitution to a client, the board, or other injured party.

E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:438 (July 1988), amended LR 25:1095 (June 1999), LR 37:2154 (July 2011), LR 41:1680 (September 2015).

§117. Exemptions

A. No person shall engage in the practice of dietetics/nutrition in the state of Louisiana unless he or she has in his or her possession a current license or provisional license duly issued by the board under the provisions of Chapter 1 of these rules, unless exempted as defined in R.S. 37:3093 of the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition LR 14:435 (July 1988), amended LR 41:1680 (September 2015).

Chapter 3. Board Members

§301. Board Members

A. Officers. The board shall elect annually at the last meeting of the calendar year, a chairman, vice-chairman, and secretary/treasurer whose responsibilities are included in the policy and procedure manual.

B. - B.1. ...

2. A schedule of meeting dates shall be published on the board's website.

3. ...

4. Special travel requests, other than regular monthly meetings, must be approved by the board.

C. - C.2.d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 37:2155 (July 2011), amended LR 41:1680 (September 2015).

Chapter 5. Procedural Rules

§503. Investigation of Complaints

A. The board is authorized to receive complaints from any person against dietitian/nutritionist licensees or applicants or against persons engaged in the unauthorized and unlicensed practice of dietetics and nutrition. Any complaint bearing on a licensee's professional competence, conviction of a crime, unauthorized practice, violation of provisions of the Dietitian/Nutritionist Practice Act or board rules and regulations, mental competence, neglect of practice or violation of the state law or ethical standards where applicable to the practice of dietetics and nutrition, should be submitted to the board.

B. Once a written and signed complaint is received from an individual, the board will initiate a review of the allegations. The board may dispose of the complaint informally through correspondence or conference with the individual and/or the complainant which may result in a consent agreement and order. If the party stipulates to the complaint and waives his or her right to formal hearing, the board may impose appropriate sanctions without delay. If the board finds that a complaint cannot be resolved informally, the written complaint will be forwarded to the board's designated complaint investigation officer (hereinafter referred to as the CIO) for investigation.

C. The board's CIO shall have authority to investigate the nature of the complaint against a licensee through conference and correspondence directed to those parties or witnesses involved. The officer shall send the involved licensee notice of the investigation, containing a short summary of the complaint. All letters to the involved licensee, the complainant, or any other witness, shall be sent by certified mail, with the designation "personal and confidential" clearly marked on the outside of the envelope.

D. The CIO shall conclude the investigation as quickly as possible without compromising thoroughness. Unless good cause is shown by the CIO satisfactory to the board, which may extend the time for the investigation, the investigation and recommended action shall be completed within 60 days of the date the CIO first receives the complaint.

E. The CIO shall make a recommendation to the board for disposition by informal hearing, formal hearing or dismissal of the complaint. When the CIO's recommended action might lead to denial, suspension, or revocation of the certificate, the board shall immediately convene a formal adjudication hearing, pursuant to R.S. 37:3090(B) of the Dietetic/Nutrition Practice Act and §501 and §503 of these regulations. The CIO may determine that the licensee's explanation satisfactorily answers the complaint and may

recommend to the board that the matter be dismissed. The recommended remedial action or dismissal of the complaint shall be forwarded to the involved complainant and licensee.

F. The CIO may also recommend to resolve the complaint through a consent agreement and order entered into by the licensee and the complainant. If the order contains any agreement by the licensee to some remedial course of action, the agreement must be signed by the complainant, the licensee and the board. The CIO will make note of any settlement arrived at between the complainant and the licensee, but such a settlement does not necessarily preclude further disciplinary action by the board.

G. If the CIO's recommendation for informal hearing is accepted by the board, the officer shall notify the licensee of the time and place of the conference and of the issues to be discussed. The licensee shall appear on a voluntary basis. The licensee shall be advised that the hearing will be informal, no lawyers will be utilized and no transcript of the hearing made. Any witnesses used will not be placed under oath, and no subpoenas will be issued. The licensee shall be informed that any statements made at the informal hearing may not be used or introduced at a formal hearing, unless all parties consent, in the event the complaint cannot be resolved informally. If the licensee notifies the CIO that he does not wish such an informal hearing, none shall be held. In that event, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

H. If the investigation disclosed any of the following:

1. that the complaint is sufficiently serious to require formal adjudication;
2. the licensee fails to respond to the CIO's correspondence concerning the complaint;
3. the licensee's response to the CIO's letter discloses that further action is necessary; an informal hearing is held but does not resolve all the issues; or the licensee refuses to comply with the recommended remedial action, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

I. In any recommended action submitted to the board by the CIO, the recommended action should be submitted in brief, concise language, without any reference to the particulars of the investigation, or any findings of fact or conclusions of law arrived at during the investigative process.

J. The board shall also have authority to delegate to the CIO the investigation of any alleged violations of R.S. 37:3090(A), prior to board action on such alleged violations. In that event, the CIO shall submit to the board the complete details of the investigation, including all facts and the complete investigation file, if requested by the board. Final authority for appropriate action rests solely with the board.

K. At no time shall the CIO investigate any case as authorized by the board or §503 where said officer has any personal or economic interest in the outcome of the investigation, or is personally related to or close friends with the complainant, the individual, or any of the involved witnesses. In such event, the officer shall immediately contact the board, who shall have authority to appoint a CIO ad hoc for disposition of that case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12

(January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1096 (June 1999), amended LR 37:2155 (July 2011), LR 41:1680 (September 2015).

§505. Conduct of Hearing

A. - A.1.d. ...

e. In any compliance hearing, the burden shall be on the applicant or licensee to establish that he or she meets the criteria for licensure or that his or her certificate was timely renewed.

1.f. - 2.d. ...

e. When the licensee receives notice, he or she may file an answer to the notice denying some or all of the charges, or offering any explanation or assert whatever defense is deemed applicable.

f. - k. ...

1. The burden of proof rests upon the attorney general who is bringing the charge before the board. No sanctions shall be imposed or order be issued, except upon consideration of the whole record, as supported by and in accordance with reliable, probative and substantial evidence as cited in R.S. 49:957.

m. Any party or person deemed to be governed by or under the jurisdiction of R.S. 37:3081-3093, may apply to the board for a declaratory order or ruling in order to determine the applicability of a statutory provision or rule of this board to said party or person. The board shall issue the declaratory order or ruling in connection with the request by majority vote of the board, signed and mailed to the requesting party within 30 days of the request, except that the board may seek legal counsel or an attorney general's opinion in connection with the request, in which case the declaratory order or ruling may be issued within 60 days of its request.

n. Judicial review and appeal of any decision or order of the board shall be governed by R.S. 49:964, 965.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093 and R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1097 (June 1999), amended LR 41:1681 (September 2015).

Jolie Jones
Executive Director

1509#009

RULE

Department of Health and Hospitals Bureau of Health Services Financing

Behavioral Health Service Providers
Licensing Standards
(LAC 48:I.Chapters 56, 57, and 74
and LAC 48.III.Chapter 5)

The Department of Health and Hospitals, Bureau of Health Services Financing has repealed LAC 48:I.Chapter 74 governing licensing standards for substance abuse/addiction treatment facilities and LAC 48:III.Chapter 5 governing licensing standards for mental health clinics in their entirety, and adopted LAC 48:I.Chapters 56 and 57

governing the licensing standards for behavioral health service providers as authorized by R.S. 36:254 and R.S. 40:2151-2161 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH—GENERAL

Part 1. General Administration

Subpart 3. Licensing

Chapter 56. Behavioral Health Service Providers

Subchapter A. General Provisions

§5601. Introduction

A. Pursuant to R.S. 40:2151-2161, the Department of Health and Hospitals (DHH) hereby establishes licensing standards for behavioral health service (BHS) providers. The purpose of these Chapters is to provide for the development, establishment and enforcement of statewide licensing standards for the care of clients receiving services from BHS providers, to ensure the maintenance of these standards, and to regulate conditions of these providers through a program of licensure that shall promote safe and adequate treatment of clients of BHS providers.

B. In addition to the requirements stated herein, all licensed BHS providers shall comply with applicable local, state, and federal laws and regulations.

C. The following providers shall be licensed under the BHS provider license:

1. substance abuse/addiction treatment facilities;
2. mental health clinics; and
3. any other entity that meets the definition of a BHS provider.

D. Licensed substance abuse/addiction treatment facilities and mental health clinics have one year from the date of promulgation of the final Rule to comply with all of the provisions herein.

NOTE: Existing licensed substance abuse/addiction treatment facilities and mental health clinics shall be required to apply for a BHS provider license at the time of renewal of their current license(s).

E. The following entities shall be exempt from the licensure requirements for BHS providers:

1. hospitals licensed under R.S. 40:2100 et seq.;
2. crisis receiving centers licensed under 40:2180.11 et seq.;
3. nursing homes licensed under R.S. 40:2009.3 et seq.;
4. psychiatric residential treatment facilities and therapeutic group homes licensed under R.S. 40:2009;
5. facilities or services operated by the federal government;
6. federally qualified health care centers (FQHCs) certified by the federal government;
7. community mental health centers (CMHCs) certified by the federal government, that provide CMHC services allowed by the federal government;
8. home and community-based service (HCBS) providers providing HCBS services under a license issued pursuant to R.S. 40:2120.1 et seq.;
9. an individual licensed mental health professional (LMHP), whether incorporated or unincorporated, or a group practice of LMHPs, providing services under the auspices of

and pursuant to the scope of the individual's license or group's licenses;

10. an individual licensed physician, or a group of licensed physicians, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

11. an individual licensed physician assistant, or a group practice of licensed physician assistants, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

12. school-based health clinics/centers that are certified by the Department of Health and Hospitals, Office of Public Health, and enrolled in the Medicaid Program;

13. a health care provider or entity solely providing case management or peer support services, or a combination thereof;

14. a health care provider that meets all of the following criteria:

a. was an accredited mental health rehabilitation provider enrolled in the Medicaid Program as of February 28, 2012;

b. was enrolled with the statewide management organization for the Louisiana Behavioral Health Partnership (LBHP) as of March 1, 2012;

c. maintains continuous, uninterrupted accreditation through a DHH authorized accreditation organization;

d. maintains continuous, uninterrupted enrollment with the statewide management organization for the LBHP;

NOTE: This exemption from licensure encompasses those mental health rehabilitation providers performing mental health rehabilitation services. It does not include a mental health rehabilitation provider that performs other services. If a mental health rehabilitation provider performs behavioral health services other than mental health rehabilitation services, the provider shall be licensed according to these licensing rules.

15. an individual licensed advanced practice registered nurse, or a group practice of licensed advanced practice registered nurses, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

16. rural health clinics (RHCs) providing RHC services under a license issued pursuant to R.S. 40:2197; and

17. facilities or services operated by the Department of Public Safety and Corrections, Corrections Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1682 (September 2015).

§5603. Definitions

Abuse—the infliction of physical or mental injury or the causing of the deterioration of an individual by means including, but not limited to, sexual *abuse*, or exploitation of funds or other things of value to such an extent that his health or mental or emotional well-being is endangered. Injury may include, but is not limited to: physical injury, mental disorientation, or emotional harm, whether it is caused by physical action or verbal statement or any other act or omission classified as abuse by Louisiana law, including, but not limited to, the *Louisiana Children's Code*.

Accredited—the process of review and acceptance by an accreditation body.

Active Client—a client that is being treated for addictive disorders at least every 90 days or a client that is being treated for mental health disorders at least every 180 days.

Addictionologist—a licensed physician who is either of the following:

1. certified by the American Board of Psychiatry and Neurology with a subspecialty in addiction psychiatry; or
2. certified by the American Board of Addiction Medicine.

Addiction Outpatient Treatment Program (ASAM Level I)—an outpatient program that offers comprehensive, coordinated, professionally directed and defined addiction treatment services that may vary in level of intensity and may be delivered in a wide variety of settings. Services are provided in regularly scheduled sessions of fewer than nine contact hours a week.

Administrative Procedure Act (APA)—R.S. 49:950 et seq.

Admission—the formal acceptance of an individual for assessment and/or therapeutic services provided by the BHS provider.

Adolescent—an individual 13 through 17 years of age.

ADRA—Addictive Disorder Regulatory Authority.

Adult—an individual 18 years of age or older.

Advance Practice Registered Nurse (APRN)—a licensed registered nurse who meets the criteria for an *advanced practice registered nurse* as established by the Louisiana State Board of Nursing and is licensed as an *APRN* and in good standing with the Louisiana State Board of Nursing.

Ambulatory Detoxification with Extended on-site Monitoring (ASAM Level II-D)—an organized outpatient addiction treatment service that may be delivered in an office setting or health care or behavioral health services provider by trained clinicians who provide medically supervised evaluation, detoxification and referral services. The services are designed to treat the client's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the client's entry into ongoing treatment and recovery. The services are provided in conjunction with intensive outpatient treatment services (level II.1).

ASAM—American Society of Addiction Medicine.

Authorized Licensed Prescriber—a physician, physician assistant, nurse practitioner, or medical psychologist licensed in the state of Louisiana and with full prescriptive authority who is authorized by the BHS provider to prescribe treatment to clients of the specific BHS provider at which he/she practices.

Behavioral Health Service (BHS) Provider or Provider—a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services, presents itself to the public as a *provider* of behavioral health services.

Behavioral Health Services—mental health services, substance abuse/addiction treatment services, or a combination of such services, for adults, adolescents and children. Such services may be provided in a residential setting, in a clinic setting on an outpatient basis, or in a home or community setting.

Building and Construction Guidelines—structural and design requirements applicable to the BHS provider which does not include occupancy requirements.

Business Location—the licensed location and office of the BHS provider that provides services only in the home and/or community.

Case Management—the coordination of services, agencies, resources, or people within a planned framework of action toward the achievement of goals established in the treatment plan that may involve liaison activities and collateral contracts with other providers.

Certified Addiction Counselor (CAC)—pursuant to R.S. 37:3387.1, any person who, by means of his specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is certified by the ADRA as a *CAC*. The *CAC* may not practice independently and may not render a diagnostic impression.

Change of Ownership (CHOW)—the sale or transfer whether by purchase, lease, gift or otherwise of a BHS provider by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a BHS provider or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the BHS provider.

Child—an individual under the age of 13.

Client—any person who has been accepted for treatment or services, including rehabilitation services, furnished by a provider licensed pursuant to this Chapter.

Client Education—information that is provided to clients and groups concerning alcoholism and other drug abuse, positive lifestyle changes, mental health promotion, suicide prevention and intervention, safety, recovery, relapse prevention, self-care, parenting, and the available services and resources. Educational group size is not restricted and may be offered as an outreach program.

Client Record—a single complete record kept by the provider which documents all treatment provided to the client and actions taken by the provider on behalf of the client. The record may be electronic, paper, magnetic material, film or other media.

Clinical Services—treatment services that include screening, assessment, treatment planning, counseling, crisis mitigation and education.

Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)—a residential program that offers continuous observation, monitoring, and treatment by clinical staff designed to treat clients experiencing substance-related disorders who have clinically-relevant social and psychological problems, such as criminal activity, impaired functioning and disaffiliation from mainstream values, with the goal of promoting abstinence from substance use and antisocial behavior and affecting a global change in clients' lifestyles, attitudes and values.

Clinically Managed Low Intensity Residential Treatment Program (ASAM Level III.1)—a residential program that offers at least five hours a week of a combination of low-intensity clinical and recovery-focused services for substance-related disorders. Services may include individual, group and family therapy, medication management and medication education, and treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility

and reintegrating the client into the worlds of work, education and family life (e.g., halfway house).

Clinically Managed Medium-Intensity Residential Treatment Program (ASAM Level III.3)—a residential program that offers at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services in a structured recovery environment to support recovery from substance-related disorders; is frequently referred to as extended or long term care.

Clinically Managed Residential Detoxification or Social Detoxification (ASAM LEVEL III.2D)—an organized residential program utilizing 24 hour active programming and containment provided in a non-medical setting that provides relatively extended, sub-acute treatments, medication monitoring observation, and support in a supervised environment for a client experiencing non-life threatening withdrawal symptoms from the effects of alcohol/drugs and impaired functioning and who is able to participate in daily residential activities.

Community Psychiatric Support and Treatment (CPST)—goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the client's individualized treatment plan. These supports and interventions are designed to improve behavioral health outcomes by utilizing evidence-based driven care.

Compulsive Gambling—persistent and recurrent maladaptive gambling behavior that disrupts personal, family, community, or vocational pursuits, and is so designated by a court, or diagnosed by a licensed physician or LMHP.

Controlled Dangerous Substance—any substance defined, enumerated, or included in federal or state statute or regulations or any substance which may hereafter be designated as a *controlled dangerous substance* by amendment of supplementation of such regulations or statute. The term shall not include distilled spirits, wine, malt beverages, or tobacco.

Core Services—the essential and necessary elements required of every BHS provider, when indicated, including assessment, orientation, client education, consultation with professionals, counseling services, referral, crisis mitigation, medication management, rehabilitation services, and treatment.

Counselor in Training (CIT)—a person currently registered with the Addictive Disorder Regulatory Authority (ADRA) and pursuing a course of training in substance abuse/addiction treatment counseling which includes educational hours, practicum hours, and direct, on-site supervision.

Crime of Violence—an offense listed as a *crime of violence* in R.S. 14:2.

Crisis Intervention—face to face intervention provided to a client who is experiencing a psychiatric crisis. The services are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation with referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Crisis Mitigation Services—a BHS provider's assistance to clients during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide

support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services.

Deemed Status—following the issuance of an initial license, the department's acceptance of the BHS provider's accreditation as compliance with this Chapter in lieu of on-site licensing surveys.

Department—the Louisiana Department of Health and Hospitals (DHH) or any office or agency thereof designated by the secretary to administer the provisions of this Chapter.

Dependent Children—any child/adolescent under the age of 18 that relies on the care of a parent or legal guardian.

DHH Authorized Accreditation Organization—any organization authorized by DHH to accredit behavioral health providers.

Diagnosis—the act of identifying a disease or behavioral health disorder as defined by the current version of the Diagnostic and Statistical Manual (DSM). A *diagnosis* is determined by a qualified LMHP or physician based on comprehensive assessment of physical evidence (if related to diagnosis), signs and symptoms, clinical and psycho-social evidence, and individual/family history.

Direct Care Staff—any member of the staff, including an employee, contractor or volunteer, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance, and clerical staff are not considered as *direct care staff*.

Disaster or Emergency—a local, community-wide, regional or statewide declared health crisis or event.

Dispense or Dispensing—the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. *Dispense* necessarily includes a transfer of possession of a drug or device to the patient or the patient's agent.

Dispensing Physician—any physician in the state of Louisiana who is registered as a *dispensing physician* with the Louisiana State Board of Medical Examiners and who dispenses to his/her patients any drug, chemical, or medication, except a bona fide medication sample.

Division of Administrative Law (DAL)—the Louisiana Department of State Civil Service, Division of Administrative Law or its successor.

Exploitation—act or process to use (either directly or indirectly) the labor or resources of an individual or organization for monetary or personal benefit, profit, or gain.

Facility Need Approval (FNA)—the letter of approval from the Office of Behavioral Health which is required for licensure applicants for opioid treatment programs prior to applying for a BHS provider license.

FDA—the United States Food and Drug Administration.

Financial Viability—the provider seeking licensure is able to provide verification and continuous maintenance of all of the following pursuant to R.S. 40:2153:

1. a line of credit issued from a federally insured, licensed lending institution in the amount of at least \$50,000;
2. general and professional liability insurance of at least \$500,000; and
3. workers' compensation insurance.

Grievance—a formal or informal written or verbal complaint that is made to the provider by a client or the client’s family or representative regarding the client’s care, abuse or neglect when the complaint is not resolved by staff present at the time of the complaint.

Health Standards Section (HSS)—the licensing and certification section of the Department of Health and Hospitals.

High Risk Behavior—includes substance abuse, gambling, violence, academic failure, delinquency behavior, and mental health issues such as depression, anxiety, and suicidal ideations.

Human Services District or Authority—an existing or newly created local governmental entity with local accountability and management of behavioral health and developmental disabilities services as well as any public health or other services contracted to the district by the department.

Human Services Field—an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior.

Intensive Outpatient Treatment Program (ASAM Level II.1)—professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting, including individual, group, family counseling and psycho-education on recovery as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis mitigation coverage and orientation to community-based support groups. Services may be offered during the day, before or after work or school, in the evening or on a weekend, and the program must provide nine or more hours of structured programming per week for adults and six or more hours of structured programming per week for children/adolescents.

Level of Care—intensity of services provided by the provider.

Licensed Addiction Counselor (LAC)—any person who, by means of his specific knowledge, acquired through formal education and practical experience, is qualified to provide addiction counseling services and is licensed by the ADRA as a licensed addiction counselor or pursuant to R.S. 37:3387.

Licensed Clinical Social Worker (LCSW)—a person duly licensed to independently practice clinical social work under R.S. 37:2702 et seq.

Licensed Marriage and Family Therapist (LMFT)—a person to whom a license has been issued and who is licensed to perform the professional application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals, couples and families. An LMFT is not permitted to diagnose a behavioral health disorder under his/her scope of practice under state law.

Licensed Mental Health Professional (LMHP)—an individual who is currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts and the individual’s professional license, as one of the following:

1. medical psychologist;
2. licensed psychologist;
3. licensed clinical social worker (LCSW);

4. licensed professional counselor (LPC);
5. licensed marriage and family therapist (LMFT);
6. licensed addiction counselor (LAC);
7. advance practice registered nurse (APRN); or
8. licensed rehabilitation counselor (LRC).

Licensed Professional Counselor—any person who holds himself out to the public for a fee or other personal gain, by any title or description of services incorporating the words “*licensed professional counselor*” or any similar term, and who offers to render professional mental health counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to practice mental health counseling.

Licensed Psychologist—any person licensed as a psychologist pursuant to R.S. 37:2352.

Licensed Rehabilitation Counselor (LRC)—any person who holds himself out to the public, for a fee or other personal gain, by any title or description of services incorporating the words “*licensed professional vocational rehabilitation counselor*” or any similar terms, and who offers to render professional rehabilitation counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill, and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to engage in the practice of rehabilitation counseling. An LRC is also known as a licensed professional vocational rehabilitation counselor. An LRC is not permitted to provide assessment or treatment services for substance abuse/addiction, mental health or co-occurring disorders under his/her scope of practice under state law.

Master’s-Prepared—an individual who has completed a master’s degree in social work or counseling, but has not met the requirements for licensing by the appropriate state board.

Medical Psychologist—a licensed psychological practitioner who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the Louisiana State Board of Medical Examiners.

Medically Managed Residential Detoxification (Medically Supported Detoxification) (ASAM Level III.7D)—a residential program that provides 24-hour observation, monitoring and treatment delivered by medical and nursing professionals to clients whose withdrawal signs and symptoms are moderate to severe and thus require residential care, but do not need the full resources of an acute care hospital.

Medically Monitored Intensive Residential Treatment Program (ASAM Level III.7)—a residential program that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment to clients with co-occurring psychiatric and substance disorders whose disorders are so severe that they require a residential level of care but do not need the full resources of an acute care hospital. The program provides 24 hours of structured treatment activities per week, including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, and habitative and rehabilitation services.

Medication Administration—preparation and/or giving of a legally prescribed individual dose of medication to a client by qualified staff including observation and monitoring of a client’s response to medication.

Mental Health Service—a service related to the screening, diagnosis, management, or treatment of a mental disorder, mental illness, or other psychological or psychiatric condition or problem.

Minor—any person under the age of 18.

Mothers with Dependent Children Program or Dependent Care Program—a program that is designed to provide substance abuse/addiction treatment to mothers with dependent children who remain with the parent while the parent is in treatment.

Neglect—the failure to provide the proper or necessary medical care, nutrition or other care necessary for a client’s well-being or any other act or omission classified as *neglect* by Louisiana law.

Non-Ambulatory—unable to walk or accomplish mobility without assistance.

Non-Prescription Medication—medication that can be purchased over-the-counter without an order from a licensed practitioner.

Nurse—any registered *nurse* licensed and in good standing with the Louisiana State Board of Nursing or any practical *nurse* licensed and in good standing with the Louisiana State Board of Practical Nurse Examiners.

OBH—the DHH Office of Behavioral Health.

Off-Site—a parent facility’s alternate program that provides behavioral health services on a routine basis in a geographic location that:

1. is detached from the parent provider;
2. is owned by, leased by or donated or loaned to the parent provider for the purpose of providing behavioral health services; and
3. has a sub-license issued under the parent facility’s license.

OHSEP—Office of Homeland Security and Emergency Preparedness.

On Call—immediately available for telephone consultation and less than one hour from ability to be on duty.

On Duty—scheduled, present and awake at the site to perform job duties.

OPH—the DHH Office of Public Health.

Opioid Treatment Program—a program that engages in medication-assisted opioid treatment of clients with an opioid agonist treatment medication.

OSFM—the Louisiana Department of Public Safety and Corrections, Office of State Fire Marshal.

Outpatient Clinic—a BHS provider that provides behavioral health services on-site at the provider’s geographic location but is not a residential provider.

Outpatient Services—behavioral health services offered in an accessible non-residential setting to clients whose physical and emotional status allows them to function in their usual environment.

Parent Facility—the main building or premises of a behavioral health service provider where services are provided on-site and administrative records are maintained.

Physical Environment—the BHS provider’s licensed exterior and interior space where BH services are rendered.

Physician—an individual who is currently licensed and in good standing in the state of Louisiana to practice medicine in Louisiana and who is acting within the scope of all applicable state laws and the individual’s professional license.

Physician Assistant—an individual who is currently approved and licensed by and in good standing with the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed by and registered with the Louisiana State Board of Medical Examiners to supervise a *physician assistant*, and who is acting within the scope of all applicable state laws and the individual’s professional license.

Plan Review—the process of obtaining approval for construction plans and specifications for the BHS provider.

Prescription Medication—medication that requires an order from a licensed practitioner and that can only be dispensed by a pharmacist on the order of a licensed practitioner or a dispensing physician and requires labeling in accordance with R.S. 37:1161 et seq.

Professional Board(s)—the entity responsible for licensure or certification for specific professions (e.g., nursing, counselors, social workers, physicians, etc.).

Psychosocial Rehabilitation (PSR)—face to face intervention with the client designed to assist with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with his/her mental illness.

Qualifying Experience—experience used to qualify for any position that is counted by using 1 year equals 12 months of full-time work.

Recovery Focused Services—services such as life skills training, job readiness, self-help meetings, parenting skills, training and recreation activities that should be coordinated with clinical services.

Referral—the BHS provider identifies needed services not provided by the provider and assists the client/family to optimally utilize the available support systems and community resources to meet the client’s needs.

Registered Addiction Counselor (RAC)—pursuant to R.S. 37:3387.2, any person who, by means of his/her specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is registered by the ADRA as a *RAC*. The *CAC* may not practice independently and may not render a diagnostic impression.

Rehabilitative Services—services intended to promote the maximum reduction of symptoms and/or restoration of the client to his/her best age-appropriate functional level according to an individualized treatment plan.

Residential Treatment Program—a planned regimen of 24-hour professionally-directed evaluation, observation, monitoring and treatment of behavioral health conditions according to a treatment plan.

Secretary—the *secretary* of the Department of Health and Hospitals or his/her designee.

Self-Administration—the client’s preparation and direct application of a medication to his/her own body by injection, inhalation, ingestion or any other means.

Shelter in Place—a provider’s decision to stay on-site rather than evacuate during a disaster or emergency.

Site/Premises—a single identifiable geographical location owned, leased, or controlled by a provider where any element of treatment is offered or provided. Multiple buildings may be contained in the license only if they are connected by walk-ways and not separated by public streets, or have different geographical addresses.

Staff—individuals who provide services for the provider including employees, contractors, consultants and volunteers.

State Opioid Authority (SOA)—the agency or other appropriate officials designated by the governor or his/her designee, to exercise the responsibility and authority within the state for governing the treatment of opiate addiction with an opioid drug. The *state opioid authority* for the state of Louisiana is the Office of Behavioral Health.

Stock Medication—any medication obtained through a pharmacy or pharmacy contract that is not designated for a specific client.

Substance Abuse/Addiction Treatment Service—a service related to the screening, diagnosis, management, or treatment for the abuse of or addiction to controlled dangerous substances, drugs or inhalants, alcohol, problem gambling or a combination thereof; may also be referred to as *substance use disorder service*.

Take-Home Dose(s)—a dose of opioid agonist treatment medication dispensed by a dispensing physician or pharmacist to a client for unsupervised use, including for use on Sundays, state and federal holidays, and emergency closures per DHH directive.

Therapeutic Counseling Services or Sessions—individual or group therapeutic treatment that teaches skills to assist clients, families, or groups in achieving objectives through exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions and decision making and problem solving. *Therapeutic counseling sessions* consist of no more than 15 clients and last at least 15 minutes.

Treatment—the application of planned procedures to identify and change patterns of behaviors that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

Treatment Plan—the provider's documentation of the client's issues, needs, ongoing goals and objectives of care based on admission information and updated based on the client's response to treatment.

Unlicensed Professional (UP)—for purposes of this Rule, any unlicensed behavioral health professional who cannot practice independently or without supervision by a LHMP. This includes but is not limited to CACs, RACs and unlicensed addiction counselors, social workers or psychologists.

Volunteer—an individual who offers services on behalf of the provider for the benefit of the provider willingly and without pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1682 (September 2015).

Subchapter B. Licensing

§5605. General Provisions

A. All BHS providers shall be licensed by the DHH. It shall be unlawful to operate as a BHS provider without a license issued by the department.

B. A BHS provider license authorizes the provider to provide behavioral health services.

C. A BHS provider license shall:

1. be issued only for the person/entity and premises named in the license application;

2. be valid only for the BHS provider to which it is issued and only for one geographic address of that provider approved by DHH;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the BHS provider;

5. be invalid if sold, assigned, donated or transferred, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

D. To be considered operational and retain licensed status, the BHS provider shall meet the following applicable operational requirements.

1. A BHS provider providing on-site services shall:

a. have established operational hours for a minimum of 20 hours per week, as indicated on the license application or change notification approved by DHH;

b. have services available and the required direct care staff on duty at all times during operational hours to meet the needs of the clients; and

c. be able to accept referrals during operational hours.

2. A BHS provider providing services only in the home and community shall:

a. have a business location which conforms to the provisions of §5691.B of this Chapter;

b. have at least one employee on duty at the business location during stated hours of operation; and

c. have direct care staff and professional services staff employed and available to be assigned to provide services to persons in their homes or in the community upon referral for services.

E. The licensed BHS provider shall abide by any state and/or federal law, rule, policy, procedure, manual or memorandum pertaining to BHS providers.

F. Provider Names. A BHS provider is prohibited from using:

1. the same name as another provider;

2. a name that resembles the name of another provider;

3. a name that may mislead the client or public into believing it is owned, endorsed or operated by the state of Louisiana when it is not.

G. Off-Sites. A licensed BHS provider may have an off-site location with the approval of HSS that meets the following requirements.

1. The off-site may share a name with the parent facility if a geographic indicator (e.g. street, city or parish) is added to the end of the off-site name.

2. Each off-site shall be licensed as an off-site under the parent facility's license.

3. The off-site shall have written established operating hours.

4. The off-site shall operate either:

a. in the same or adjacent parish as the parent facility; or

b. for providers operated by a human service district or authority, within the jurisdiction of the district or authority.

5. A residential off-site shall be reviewed under the plan review process.

6. An initial survey may be required prior to opening a residential off-site.

7. An off-site shall have staff to comply with all requirements in this Chapter and who are present during established operating hours to meet the needs of the clients.

8. Personnel records and client records may be housed at the parent facility.

9. Clients who do not receive all treatment services at an off-site may receive the services at the parent facility or be referred to another licensed provider that provides those services.

10. The off-site may offer fewer services than the parent facility and/or may have less staff than the parent facility.

11. The off-site together with the parent facility provides all core functions of a BHS provider and meets all licensing requirements of a BHS provider.

H. Plan Review

1. Plan review is required for outpatient clinics and residential BHS provider locations where direct care services or treatment will be provided, except for the physical environment of a substance abuse/addiction treatment facility or licensed mental health clinic at the time of this Chapter's promulgation.

2. Notwithstanding the provisions in this Section, any entity that will operate as a BHS provider and is required to go through plan review shall complete the plan review process and obtain approval for its construction documents in accordance with:

a. R.S. 40:1574;

b. the current *Louisiana Administrative Code* provisions;

c. OSFM requirements; and

d. the requirements for the provider's physical environment in Subchapter H of this Chapter.

3. Any change in the type of the license shall require review for requirements applicable at the time of licensing change.

4. Upon plan review approval, the provider shall submit the following to the department:

a. a copy of the final construction documents approved by OSFM; and

b. OSFM's approval letter.

I. Waivers

1. The secretary of the DHH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the state *Sanitary Code* or the OSFM.

2. In order to request a waiver, the provider shall submit a written request to HSS that demonstrates:

a. how patient safety and quality of care are not compromised by the waiver;

b. the undue hardship imposed on the provider if the waiver is not granted; and

c. the provider's ability to completely fulfill all other requirements of service.

3. The department will make a written determination of each waiver request.

4. Waivers are not transferable in a change of ownership or geographic change of location, and are subject to review or revocation upon any change in circumstances related to the waiver.

J. The BHS provider shall maintain and make available to the department any information or records related to compliance with this Chapter.

K. The BHS provider shall permit designated representatives of the department, in performance of their duties, to:

1. inspect all areas of the BHS provider's operations; and

2. conduct interviews with any provider staff member, client or other person as necessary.

L. An owner, officer, member, manager, administrator, medical director, managing employee or clinical supervisor is prohibited from being a BHS provider, who has been convicted of or entered a guilty or nolo contendere plea to a felony related to:

1. violence, abuse or neglect against a person;

2. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

3. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

4. the misappropriation of property belonging to another person;

5. a crime of violence;

6. an alcohol or drug offense, unless the offender has:

a. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and

b. been sober per personal attestation for the last two years;

7. possession or use of a firearm or deadly weapon;

8. Medicare or Medicaid fraud; or

9. fraud or misappropriation of federal or state funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1687 (September 2015).

§5607. Initial Licensure Application Process

A. Any entity, organization or person seeking to operate as a BHS provider must submit a completed initial license application packet to the department for approval. Initial BHS provider licensure application packets are available from HSS.

B. The completed initial licensing application packet shall include:

1. a completed BHS provider licensure application;

2. the non-refundable licensing fee established by statute;

3. the plan review approval letter from OSFM, if applicable;

4. the on-site inspection report with approval for occupancy by the OSFM, if applicable;

5. the health inspection report with recommendation for licensure from the Office of Public Health;

6. a statewide criminal background check, including sex offender registry status, on all owners and managing employees;

7. except for governmental entities, proof of financial viability;

8. an organizational chart and names, including position titles of key administrative personnel and governing body;

9. a legible floor sketch or drawing of the premises to be licensed;

10. a letter of intent detailing the type of BHS provider operated by the licensee and the types of services or specializations that will be provided by the BHS provider (e.g. addiction treatment program, mental health program, residential provider, outpatient provider, opioid treatment program);

11. if operated by a corporate entity, such as a corporation or a limited liability company, current proof of registration and status with the Louisiana Secretary of State; and

12. any other documentation or information required by the department for licensure including, but not limited to, documentation for opioid treatment programs, such as a copy of the OBH FNA letter.

C. Deadline for Submitting Initial Licensure Application for Unlicensed Agencies with the OBH Certification

1. Any unlicensed agency that was certified by OBH as a provider of any psychosocial rehabilitation, crisis intervention and/or community psychiatric support and treatment services prior to the promulgation of this Rule and is required to be licensed as a BHS provider has 180 days from the promulgation of this Rule to submit an initial licensing application packet to HSS.

2. Any such unlicensed agency with OBH certification may continue to operate without a license during the licensing process until the department acts upon the initial license application and any and all appeal processes associated with the initial licensure is complete or the delay for taking an appeal has expired, whichever is later.

3. The department has the authority to issue a cease and desist order and pursue legal action for failure to comply with the deadline for submitting an initial licensure application. The cease and desist order shall require immediate discharge of all current clients and no new clients shall be admitted.

D. If the initial licensing packet is incomplete, the applicant shall:

1. be notified of the missing information; and

2. have 90 days from receipt of the notification to submit the additional requested information; if not submitted, the application shall be closed.

E. Once the initial licensing application is approved by the department, notification of such approval shall be forwarded to the applicant.

F. The applicant shall notify the department of initial licensing survey readiness within the required 90 days of receipt of application approval. If an applicant fails to notify the department of initial licensing survey readiness within 90 days, the application shall be closed.

G. If an initial licensing application is closed, an applicant who seeks to operate as a BHS provider shall submit:

1. a new initial licensing packet;

2. non-refundable licensing fee; and

3. facility need review approval, if applicable.

H. Applicants shall be in compliance with all applicable federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the BHS provider will be issued an initial license to operate.

I. A BHS provider is prohibited from providing behavioral health services to clients during the initial application process and prior to obtaining a license, unless the applicant qualifies as one of the following facilities:

1. a licensed mental health clinic;

2. a licensed substance abuse/addiction treatment facility; or

3. an agency that is certified by OBH as a provider of psychosocial rehabilitation, community psychiatric support and treatment, and/or crisis intervention services.

J. Off-Sites. In order to operate an off-site, the provider must submit:

1. a request for opening an off-site location;

2. a completed application, including established operational hours;

3. payment of applicable fees;

4. current on-site inspection reports from OSFM and OPH; and

5. for any residential off-site, plan review approval from OSFM.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1688 (September 2015).

§5609. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial licensing survey shall be announced and conducted on-site to ensure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the provider is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department may issue a full license to the provider.

C. In the event that the initial licensing survey finds that the provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, that present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license. If the department denies an initial license, the applicant for a BHS provider license shall discharge the clients receiving services.

D. In the event that the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, and the department determines that the noncompliance does not

present a threat to the health, safety or welfare of the clients, the department may:

1. issue a provisional initial license for a period not to exceed six months; and/or
2. conduct a follow-up survey following the initial licensing survey to ensure correction of the deficiencies.
 - a. Follow-up surveys to the initial licensing surveys are unannounced surveys.
 - b. If all deficiencies are corrected on the follow-up survey, a full license may be issued.
 - c. If the provider fails to correct the deficiencies, the initial license may be denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1689 (September 2015).

§5611. Types of Licenses

A. The department has the authority to issue the following types of licenses.

1. Initial License
 - a. The department may issue a full license to the BHS provider when the initial licensing survey indicates the provider is compliant with:
 - i. all licensing laws and regulations;
 - ii. all other required statutes, laws, ordinances, rules, regulations; and
 - iii. fees.
 - b. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.
2. Provisional Initial License. The department may issue a provisional initial license to the BHS provider when the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.
 - a. The provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.
 - b. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license may be issued.
 - c. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license may expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fees.
3. Renewal License. The department may issue a renewal license to a licensed BHS provider that is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended.

4. Provisional License. The department may issue a provisional license to a licensed BHS provider for a period not to exceed six months.

- a. A provisional license may be issued for one of the following reasons:
 - i. more than five deficiencies cited during any one survey;
 - ii. four or more validated complaints in a consecutive 12-month period;
 - iii. a deficiency resulting from placing a client at risk for serious harm or death;
 - iv. failure to correct deficiencies within 60 days of notification of such deficiencies or at the time of a follow-up survey; or
 - v. failure to be in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.
- b. The department may extend the provisional license for an additional period not to exceed 90 days in order for the provider to correct the deficiencies.
- c. The provider shall:
 - i. submit a plan of correction to the department for approval; and
 - ii. correct all noncompliance or deficiencies prior to the expiration of the provisional license.
- d. The department may conduct a follow-up survey, either on-site or by administrative review, of the BHS provider prior to the expiration of the provisional license.
- e. If the follow-up survey determines that the BHS provider has corrected the deficiencies and has maintained compliance during the period of the provisional license, the department may issue a license that will expire on the expiration date of the most recent renewal or initial license.
- f. The provisional license may expire if:
 - i. the provider fails to correct the deficiencies by the follow-up survey; or
 - ii. the provider is cited with new deficiencies at the follow-up survey indicating a risk to the health, safety or welfare of a client.
- g. If the provisional license expires, the provider shall be required to begin the initial licensing process by submitting the following:
 - i. a new initial licensing application packet;
 - ii. a non-refundable licensing fee; and
 - iii. facility need review approval, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1690 (September 2015).

§5613. Changes in Licensee Information or Personnel

- A. A BHS provider shall report in writing to HSS within five days of any change of the following:
1. BHS provider's entity name;
 2. business name;
 3. mailing address;
 4. telephone number; or
 5. email address of the administrator.

B. Any change to the BHS provider's name or doing business as name requires the nonrefundable fee for the issuance of an amended license with the new name.

C. A BHS provider shall report in writing to the HSS any change in the provider's key administrative personnel within five days of the change.

1. Key administrative personnel include the following:
 - a. administrator;
 - b. medical director; and
 - c. clinical supervisor.

2. The BHS provider's written notice to HSS shall include the individual's:

- a. name;
- b. hire date; and
- c. qualifications.

D. Change of Ownerships

1. A BHS provider shall report a change of ownership (CHOW) in writing to HSS within five days following the change. The new owner shall submit the following:

- a. the legal CHOW document;
- b. all documents required for a new license; and
- c. the applicable nonrefundable licensing fee.

2. A BHS provider that is under license revocation, provisional licensure or denial of license renewal may not undergo a CHOW.

3. If there are any outstanding fees, fines or monies owed to the department by the existing licensed entity, the CHOW will be suspended until payment of all outstanding amounts.

4. Once all application requirements are completed and approved by the department, a new license may be issued to the new owner.

E. Change in Geographic Location

1. A BHS provider that seeks to change its geographic location shall submit:

- a. written notice to HSS of its intent to relocate;
- b. a plan review request, if applicable;
- c. a new license application;
- d. the nonrefundable license fee; and
- e. other applicable licensing requirements.

2. In order to receive approval for the change of geographic location, the BHS provider shall have:

- a. plan review approval, if required;
- b. approval from the OSFM and the OPH recommendation for licensure of the new geographic location;
- c. an approved license application packet;
- d. compliance with other applicable licensing requirements; and
- e. an on-site licensing survey prior to relocation of the provider.

3. Upon approval of the requirements for a change in geographic location, the department may issue a new license to the BHS provider.

F. Any request for a duplicate license shall be accompanied by the required fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1690 (September 2015).

§5615. Renewal of License

A. A BHS provider license shall expire on the expiration date listed on the license, unless timely renewed by the BHS provider.

B. To renew a license, the BHS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet shall include:

1. the license renewal application;
2. a current OSFM report;
3. a current OPH inspection report;
4. the non-refundable license renewal fee as established by statute;
5. except for governmental entities, proof of financial viability;
6. payment of any outstanding fees, fines or monies owed to the department; and
7. any other documentation required by the department.

C. The department may perform an on-site survey and inspection of the provider upon renewal.

D. Failure to submit a completed license renewal application packet prior to the expiration of the current license may result in the voluntary non-renewal of the BHS provider license upon the license expiration.

E. The renewal of a license does not affect any sanction, civil monetary penalty or other action imposed by the department against the provider.

F. If a licensed BHS provider has been issued a notice of license revocation or suspension, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

G. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license:

- a. expires on the license's expiration date; and
- b. is considered a non-renewal and voluntarily surrendered.

2. There is no right to an administrative reconsideration or appeal for a voluntary surrender or non-renewal of the license.

3. If a provider fails to timely renew its license, the provider shall immediately cease providing services. If the provider is actively treating clients, the provider shall:

- a. within two days of voluntary non-renewal, provide written notice to HSS of the number of clients receiving treatment;
- b. within two days of voluntary non-renewal, provide written notice to each active client's prescribing physician and to every client, or, if applicable, the client's parent or legal guardian, of the following:
 - i. voluntary non-renewal of license;
 - ii. date of closure; and
 - iii. plans for the transition of the client;
- c. discharge and transition each client in accordance with this Chapter within 15 days of the license's expiration date; and

d. provide written notice to HSS of the location where client and personnel records will be stored and the name, address and telephone number of the person responsible for the records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1691 (September 2015).

§5617. Deemed Status

A. A licensed BHS provider may request deemed status once it becomes accredited by the DHH authorized accreditation organization.

B. The department may approve the deemed status request and accept accreditation in lieu of an on-site licensing survey when the provider provides documentation to the department that shows:

1. the accreditation is current and was obtained through the DHH authorized accreditation organization;

2. all behavioral health services provided under the BHS provider license are accredited; and

3. the accrediting organization's findings.

C. If deemed status is approved, accreditation will be accepted as evidence of satisfactory compliance with this Chapter in lieu of conducting a licensing survey.

D. To maintain deemed status, the provider shall submit a copy of current accreditation documentation with its annual license renewal application.

E. The department may rescind deemed status and conduct a licensing survey for the following:

1. any valid complaint within the preceding 12 months;

2. an addition of services;

3. a change of ownership;

4. issuance of a provisional license in the preceding 12-month period;

5. deficiencies identified in the preceding 12-month period that placed clients at risk for harm;

6. treatment or service resulting in death or serious injury; or

7. a change in geographic location.

F. The provider shall notify HSS upon change in accreditation status within two business days.

G. The department shall rescind deemed status when the provider loses its accreditation.

H. A BHS provider approved for deemed status is subject to and shall comply with all provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015).

§5619. Licensing Surveys

A. The department may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing behavioral health providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. If deficiencies are cited, the department may require the provider to submit an acceptable plan of correction.

C. The department may conduct a follow-up survey following any survey in which deficiencies were cited to ensure correction of the deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015).

§5621. Complaint Investigations

A. Pursuant to R.S. 40:2009.13 et seq., the department may conduct unannounced complaint investigations on all behavioral health providers, including those with deemed status.

B. The department shall issue a statement of deficiencies to the provider if deficient practice is cited as a result of the complaint investigation.

C. Upon issuance of a statement of deficiencies, the department may require the provider to submit an acceptable plan of correction.

D. The department may conduct a follow-up survey following a complaint investigation in which deficiencies were cited to ensure correction of the deficient practices.

E. Informal Reconsiderations of Complaint Investigations

1. A provider that is cited with deficiencies found during a complaint investigation has the right to request an informal reconsideration of the deficiencies. The provider's written request for an informal reconsideration must be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and must identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

2. An informal reconsideration for a complaint investigation shall be conducted by HSS as a desk review.

3. Correction of the violation or deficiency shall not be the basis for the reconsideration.

4. The provider shall be notified in writing of the results of the informal reconsideration.

5. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint investigation, and there shall be no further right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015).

§5623. Statement of Deficiencies

A. The BHS provider shall post the following statements of deficiencies issued by the department in a readily accessible place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. each of the complaint survey statements of deficiencies, including the plans of correction, issued after the most recent annual survey.

B. The BHS provider shall make its statements of deficiencies available to the public 30 days after the provider submits an acceptable plan of correction of the deficiencies or 90 days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Informal Dispute Resolution

1. Unless otherwise provided in statute or in this Chapter, a BHS provider has the right to an informal dispute resolution (IDR) of any deficiencies cited as a result of a survey.

2. Correction of the violation, noncompliance or deficiency shall not be the basis for the IDR.

3. The BHS provider's written request for IDR must be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and must identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If a timely request for an IDR is received, the department shall schedule and conduct the IDR.

5. HSS shall notify the provider in writing of the results of the IDR.

6. Except as provided for complaint surveys and as provided in this Chapter:

a. the IDR decision is the final administrative decision regarding the deficiencies; and

b. there is no right to an administrative appeal of such deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015).

§5625. Cessation of Business

A. Except as provided in §5677 of these licensing regulations, a license shall be immediately null and void if a BHS provider ceases to operate.

B. A cessation of business is deemed to be effective the date on which the BHS provider stopped offering or providing services to the community.

C. Upon the cessation of business, the BHS provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The BHS provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the BHS provider shall:

1. give 30 days advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the client, legal guardian or legal representative, if applicable, of each client; and

2. provide for an orderly discharge and transition of all of the clients in accordance with the provisions of this Chapter.

F. In addition to the advance notice of voluntary closure, the BHS provider shall submit a written plan for the disposition of client medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a BHS provider fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a BHS provider for a period of two years.

H. Once the BHS provider has ceased doing business, the BHS provider shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1693 (September 2015).

§5627. Sanctions

A. The department may issue sanctions for deficiencies and violations of law, rules and regulations that include:

1. civil fines;

2. license revocation or denial of license renewal; and

3. any sanctions allowed under state law or regulation.

B. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the Administrative Procedure Act.

C. The department may deny an initial license, revoke a license or deny a license renewal for any of the following reasons, including, but not limited to:

1. failure to be in compliance with the BHS licensing laws, rules and regulations;

2. failure to be in compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. cruelty or indifference to the welfare of the clients;

5. misappropriation or conversion of the property of the clients;

6. permitting, aiding or abetting the unlawful, illicit or unauthorized use of drugs or alcohol within the provider of a program;

7. documented information of past or present conduct or practices of BHS provider personnel which are detrimental to the welfare of the clients, including but not limited to illegal or criminal activities, or coercion;

8. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. illegal or criminal activities;

9. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in Paragraph C.8 above;

10. knowingly making a false statement in any of the following areas, including but not limited to:

- a. application for initial license or renewal of license;
- b. data forms;
- c. clinical records, client records or provider records;
- d. matters under investigation by the department or authorized law enforcement agencies; or
- e. information submitted for reimbursement from any payment source;

11. knowingly making a false statement or providing false, forged or altered information or documentation to DHH employees or to law enforcement agencies;

12. the use of false, fraudulent or misleading advertising; or

13. the BHS provider, an owner, officer, member, manager, administrator, medical director, managing employee, or clinical supervisor that has pled guilty or nolo contendere to a felony, or is convicted of a felony, as documented by a certified copy of the record of the court, related to:

- a. violence, abuse or neglect against a person;
- b. sexual misconduct and/or any crimes that require the person to register pursuant to the Sex Offenders Registration Act;
- c. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;
- d. the misappropriation of property belonging to another person;
- e. a crime of violence;
- f. an alcohol or drug offense, unless the offender has:

- i. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and
- ii. been sober per personal attestation for at least the last two years;

- g. a firearm or deadly weapon;
- h. Medicare or Medicaid fraud; or
- i. fraud or misappropriation of federal or state funds;

14. failure to comply with all reporting requirements in a timely manner, as required by the department;

15. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview BHS provider staff or clients;

16. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

17. failure to allow or refusal to allow access to BHS provider or client records by authorized departmental personnel;

18. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular BHS provider;

19. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

20. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department;

21. failure to maintain accreditation, if accreditation is a federal or state requirement for participation in the program; or

22. failure to uphold client rights that may have resulted or may result in harm, injury or death of a client.

D. Any owner, officer, member, manager, director or administrator of such BHS provider is prohibited from owning, managing, directing or operating another BHS provider for a period of two years from the date of the final disposition of any of the following:

1. license revocation;
2. denial of license renewal; or
3. the license is surrendered in lieu of adverse action.

E. If the secretary of the department determines that the health and safety of a client or the community may be at risk, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. The department will provide written notification to the BHS provider if the imposition of the action will be immediate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1693 (September 2015).

§5629. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. The department shall provide written notice to the provider of the following:

1. initial license denial;
2. license revocation; or
3. denial of license renewal.

B. The BHS provider has the right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative reconsideration, the request must:

- a. be in writing addressed to HSS;
- b. be received by HSS within 15 calendar days of the BHS provider's receipt of the notice of the initial license denial, license revocation or denial of license renewal; and
- c. include any documentation that demonstrates that the determination was made in error.

2. If a timely request for an administrative reconsideration is received, HSS shall provide the BHS provider with written notification of the date of the administrative reconsideration.

3. The HSS shall conduct the administrative reconsideration. The BHS provider may request to present an oral presentation and be represented by counsel.

4. The HSS shall not consider correction of a deficiency or violation as a basis for the reconsideration.

5. The BHS provider will be notified in writing of the results of the administrative reconsideration.

C. The administrative reconsideration process is not in lieu of the administrative appeals process.

D. The BHS provider has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative appeal, the request must be received:

a. by the DAL or its successor, within 30 days of the BHS provider's receipt of the results of the administrative reconsideration; or

b. within 30 days of the BHS provider's receipt of the notice of the initial license denial, revocation or denial of license renewal if the BHS provider chooses to forego its rights to an administrative reconsideration;

2. The provider's request for administrative appeal shall:

a. be in writing;

b. include any documentation that demonstrates that the determination was made in error; and

c. include the basis and specific reasons for the appeal.

3. The DAL shall not consider correction of a violation or a deficiency as a basis for the administrative appeal.

4. If a timely request for an administrative appeal is received by the DAL, the BHS provider shall be allowed to continue to operate and provide services until the DAL issues a final administrative decision, unless the imposition of the revocation or denial of license renewal is immediate based on the secretary's determination that the health and safety of a client or the community may be at risk.

E. If a licensed BHS provider has been issued notice of license revocation by the department, and the license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

F. Administrative Hearings of Initial License Denials, Denial of License Renewals and License Revocations

1. If a timely administrative appeal is submitted by the BHS provider, the DAL or its successor, shall conduct the hearing in accordance with the APA.

2. If the final DAL decision is to reverse the initial license denial, denial of license renewal or license revocation, the BHS provider's license will be re-instated upon the payment of any outstanding fees or sanctions fees due to the department.

3. If the final DAL decision is to affirm the denial of license renewal or license revocation, the BHS provider shall:

a. discharge and transition any and all clients receiving services according to the provisions of this Chapter; and

b. notify HSS in writing of the secure and confidential location where the client records will be stored and the name, address and phone number of the contact person responsible for the records.

G. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new BHS provider, or the issuance of a provisional license to a licensed BHS provider.

H. Administrative Reconsiderations from the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative reconsideration of the validity of the deficiencies cited at the follow up survey.

2. The BHS provider's request for an administrative reconsideration must:

a. be in writing;

b. be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

3. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative reconsideration.

4. A BHS provider with a provisional initial license or a provisional license that expires under the provisions of this Chapter, shall cease providing services and discharge or transition clients, unless the DAL or successor issues a stay of the expiration.

a. To request a stay, the BHS provider must submit its written application to the DAL at the time the administrative appeal is filed.

b. The DAL shall hold a contradictory hearing on the stay application. If the BHS provider shows that there is no potential harm to its clients, then the DAL shall grant the stay.

I. Administrative Hearing of the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative appeal of the validity of the deficiencies cited at the follow up survey.

2. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative appeal.

3. The BHS provider's request for an administrative appeal shall:

a. be in writing;

b. be submitted to the DAL within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If the BHS provider submits a timely request for an administrative hearing, the DAL shall conduct the hearing in accordance with the APA.

a. If the final DAL decision is to remove all disputed deficiencies, the department will reinstate the BHS provider's license upon the payment of any outstanding fees and settlement of any outstanding sanctions due to the department.

b. If the final DAL decision is to uphold the disputed deficiencies thereby affirming the expiration of the provisional license, the BHS provider shall discharge any

and all clients receiving services and comply with the cessation of business requirements in accordance with this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1694 (September 2015).

Subchapter C. Organization and Administration

§5631. General Provisions

A. Purpose and Organizational Structure. The BHS provider shall develop and maintain a written statement that clearly defines the purpose and organization of the provider. The statement shall include:

1. the program philosophy;
2. the program goals and objectives;
3. the ages, sex and characteristics of clients accepted for care;
4. the geographical area served;
5. the types of services provided;
6. the admission criteria;
7. the needs, problems, situations or patterns addressed by the BHS provider's program; and

8. the BHS provider's organizational chart which clearly delineates the line of authority.

B. The BHS provider shall provide supervision and services that:

1. conform to the department's rules and regulations;
2. meet the needs of the client as identified and addressed in the client's treatment plan;
3. protect each client's rights; and
4. promote the social and physical well-being and behavioral health of clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1696 (September 2015).

§5633. Governing Body

A. A BHS provider shall have the following:

1. an identifiable governing body with responsibility for and authority over the policies and operations of the BHS provider;
2. documentation identifying the governing body's:
 - a. members;
 - b. contact information for each member;
 - c. terms of membership;
 - d. officers; and
 - e. terms of office for each officer.

B. The governing body of a BHS provider shall:

1. be comprised of one or more persons;
2. hold formal meetings at least twice a year;
3. maintain written minutes of all formal meetings of the governing body; and
4. maintain by-laws specifying frequency of meetings and quorum requirements.

C. The responsibilities of a BHS provider's governing body, include, but are not limited to:

1. ensuring the BHS provider's compliance with all federal, state, local and municipal laws and regulations as applicable;
2. maintaining funding and fiscal resources to ensure the provision of services and compliance with this Chapter;

3. reviewing and approving the BHS provider's annual budget;

4. designating a qualified person to act as administrator, and delegating this person the authority to manage the BHS provider;

5. at least once a year, formulating and reviewing, in consultation with the administrator, the clinical supervisor and/or medical director, written policies concerning:

- a. the BHS provider's philosophy and goals;
- b. current services;
- c. personnel practices and job descriptions; and
- d. fiscal management;

6. evaluating the performance of the administrator at least once a year;

7. meeting with designated representatives of the department whenever required to do so;

8. informing the department, or its designee, prior to initiating any substantial changes in the services provided by the BHS provider; and

9. ensuring statewide criminal background checks are conducted as required in this Chapter and state law.

D. A governing body shall ensure that the BHS provider maintains the following documents:

1. minutes of formal meetings and by-laws of the governing body;
2. documentation of the BHS provider's authority to operate under state law;
3. all leases, contracts and purchases-of-service agreements to which the BHS provider is a party;
4. insurance policies;
5. annual operating budgets;
6. a master list of all the community resources used by the BHS provider;
7. documentation of ownership of the BHS provider;
8. documentation of all accidents, incidents, and abuse/neglect allegations; and
9. daily census log of clients receiving services.

E. Service Agreements. The governing body of a BHS provider shall ensure the following with regards to agreements to provide services for the provider:

1. the agreement for services is in writing;
2. the provider reviews all written agreements at least once a year;
3. the deliverables are being provided as per the agreement;
4. the BHS provider retains full responsibility for all services provided by the agreement;
5. all services provided by the agreement shall:
 - a. meet the requirements of all laws, rules and regulations applicable to a BHS provider; and
 - b. be provided only by qualified providers and personnel in accordance with this Chapter; and
6. if the agreement is for the provision of direct care services, the written agreement specifies the party responsible for screening, orientation, ongoing training and development of and supervision of the personnel providing services pursuant to the agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1696 (September 2015).

§5635. Policies and Procedures

A. Each BHS provider shall develop, implement and comply with provider-specific written policies and procedures related to compliance with this Chapter, including, but not limited to policies and procedures that address:

1. the protection of the health, safety, and well-being of each client;
2. the provision of treatment in order for clients to achieve recovery;
3. access to care that is medically necessary;
4. uniform screening for patient placement and quality assessment, diagnosis, evaluation, and referral to appropriate level of care;
5. operational capability and compliance;
6. delivery of services that are cost-effective and in conformity with current standards of practice;
7. confidentiality and security of client records and files;
8. client rights;
9. grievance procedures;
10. emergency preparedness;
11. abuse, neglect and exploitation of clients;
12. incidents and accidents, including medical emergencies and reporting requirements, if applicable;
13. universal precautions and infection control;
14. documentation of services;
15. admission, including screening procedures, emergency care, client orientation, walk-in services or other brief or short-term services provided.
16. transfer and discharge procedures;
17. behavior management;
18. transportation;
19. quality improvement;
20. medical and nursing services;
21. research or non-traditional treatment approaches and approval thereof, in accordance with federal and state guidelines;
22. access to and usage of laundry and kitchen facilities;
23. the BHS provider's exterior location where smoking, if allowed, may occur;
24. domestic animals, if permitted on premises that, at a minimum, include:
 - a. required animal vaccinations and updates, as indicated; and
 - b. management of the animals' care and presence consistent with the goals of the program and clients' needs, including those with allergies;
25. privacy and security of laboratory testing and screenings, if performed on-site;
26. what constitutes the authorized and necessary use of force and least restrictive measures by uniformed security as related to client behaviors and safety; and
27. compliance with applicable federal and state laws and regulations.

B. A BHS provider shall develop, implement and comply with written personnel policies that address the following:

1. recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of employees;

2. written job descriptions for each staff position, including volunteers;

3. an employee grievance procedure;

4. abuse reporting procedures that require staff to report:

- a. any allegations of abuse or mistreatment of clients according to state and federal laws; and

- b. any allegations of abuse, neglect, exploitation or misappropriation of a client to the HSS;

5. a nondiscrimination policy;

6. the requirement that all employees report any signs or symptoms of a communicable disease or contagious illness to their supervisor or the clinical supervisor as soon as possible;

7. procedures to ensure that only qualified personnel are providing care within the scope of the core functions of the provider's services;

8. the governing of staff conduct and procedures for reporting violations of laws, rules, and professional and ethical codes of conduct;

9. procedures to ensure that the staff's credentials are verified, legal and from accredited institutions; and

10. procedure to obtain statewide criminal background checks, ensuring no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable.

C. A BHS provider shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1697 (September 2015).

Subchapter D. Provider Operations

§5637. Client Records

A. The BHS provider shall ensure that:

1. a client record is maintained for each client according to current professional standards;

2. policies and procedures regarding confidentiality, maintenance, safeguarding and storage of records are developed and implemented;

3. records are stored in a place or area where safeguards are in place to prevent unauthorized access, loss, and destruction of client records;

4. when electronic health records are used, the most current technologies and practices are used to prevent unauthorized access;

5. records are kept confidential according to federal and state law and regulations;

6. records are maintained at the provider where the client is currently active and for six months after discharge;

7. six months post-discharge, records may be transferred to a centralized location for maintenance;

8. client records are directly and readily accessible to the direct care staff caring for the client;

9. a system of identification and filing is maintained to facilitate the prompt location of the client's records;

10. all record entries are dated, legible and authenticated by the staff person providing the service or treatment, as appropriate to the media used;

11. records are disposed of in a manner that protects client confidentiality;

12. a procedure for modifying a client record in accordance with accepted standards of practice is developed, implemented and followed;

13. an employee is designated as responsible for the client records;

14. disclosures are made in accordance with applicable state and federal laws and regulations;

15. client records are maintained at least 6 years from discharge, and for minors, client records are maintained at least 10 years.

B. Contents. The provider shall ensure that a client record, at a minimum, contains the following:

1. the treatment provided to the client;

2. the client's response to the treatment;

3. all pertinent medical, psychological, social and other therapeutic information, including:

a. initial assessment;

b. admission diagnosis;

c. referral information;

d. client information/data such as name, race, sex, birth date, address, telephone number, social security number, school/employer, and authorized representative, if applicable;

e. screenings;

f. medical limitations such as major illnesses, allergies;

g. treatment plan that includes the initial treatment plan plus any updates or revisions;

h. lab work including diagnostic, laboratory and other pertinent information, when indicated;

i. legible written progress notes or equivalent documentation;

j. documentation of the services delivered for each client signed by the client or responsible person for services provided in the home or community;

k. documentation related to incidents;

l. consent forms;

m. physicians' orders;

n. a record of all medicines administered by the BHS provider or self-administered by the client, including medication name and type, dosage, frequency of administration, route and person who administered each dose;

o. discharge summary; and

p. other pertinent information related to client as appropriate;

4. progress notes that are documented in accordance with professional standards of practice and that:

a. document implementation of the treatment plan and results;

b. document the client's level of participation; and

c. are completed upon delivery of services by the direct care staff to document progress toward stated treatment plan goals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1697 (September 2015).

§5639. Quality Improvement Plan

A. A BHS provider shall develop, implement and maintain a quality improvement (QI) plan that:

1. assures that the provider is in compliance with federal, state, and local laws;

2. meets the needs of the provider's clients;

3. is attaining the goals and objectives established by the provider;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual outcomes and individual satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QI plan shall include:

1. a process for obtaining input from the client, or client's parents or legal guardian, as applicable, at least once a year that may include, but not be limited to:

a. satisfaction surveys conducted by a secure method that maintains the client's privacy;

b. focus groups; and

c. other processes for receiving input regarding the quality of services received;

2. a sample review of client case records on a quarterly basis to ensure that:

a. individual treatment plans are up to date;

b. records are accurate, complete and current;

c. the treatment plans have been developed and implemented as ordered; and

d. the program involves all services and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors;

3. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the BHS provider receiving services, that includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

4. a process to review and resolve individual client issues that are identified;

5. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

6. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients;

7. a process of evaluation to identify or trigger further opportunities for improvement, such as:

a. identification of individual care and service components;

b. application of performance measures; and

c. continuous use of a method of data collection and evaluation;

8. a methodology for determining the amount of client case records in the quarterly sample review that will involve all services and produce accurate data to guide the provider toward performance improvement.

C. The QI program shall establish and implement an internal evaluation procedure to:

1. collect necessary data to formulate a plan; and
2. hold quarterly committee meetings comprised of at least three individuals who:
 - a. assess and choose which QI plan activities are necessary and set goals for the quarter;
 - b. evaluate the activities of the previous quarter; and
 - c. implement any changes that protect the clients from potential harm or injury.

D. The QI plan committee shall:

1. be comprised of at least three persons, one of whom is a LMHP and the others are staff with the qualifying experience to contribute to the committee's purpose; and
2. develop and implement the QI plan.

E. The QI program outcomes shall be documented and reported to the administrator and medical director for action, as necessary, for any identified systemic problems.

F. The BHS provider shall maintain documentation of the most recent 12 months of the QI plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1698 (September 2015).

Subchapter E. Personnel

§5641. General Requirements

A. The BHS provider shall maintain an organized professional staff who is accountable to the governing body for the overall responsibility of:

1. the quality of all clinical care provided to clients;
2. the ethical conduct and professional practices of its members;
3. compliance with policies and procedures; and
4. the documented staff organization that pertains to the provider's setting and location.

B. The direct care staff of a BHS provider shall:

1. have the qualifying experience to provide the services required by its clients' treatment plans; and
2. not practice beyond the scope of his/her license, certification and/or training.

C. The provider shall ensure that:

1. Qualified direct care staff members are present with the clients as necessary to ensure the health, safety and well-being of clients;
2. Staff coverage is maintained in consideration of:
 - a. acuity of the clients being serviced;
 - b. the time of day;
 - c. the size, location, physical environment and nature of the provider;
 - d. the ages and needs of the clients;
 - e. ensuring the continual safety, protection, direct care and supervision of clients;
3. applicable staffing requirements in this Chapter are maintained;
4. mechanisms are developed for tracking staff attendance and hours worked during operational hours whether onsite or off-site;

5. there is adequate justification for the provider's assigned staffing patterns at any point in time.

D. Criminal Background Checks

1. For any provider that is treating children and/or adolescents, the provider shall either:

- a. obtain a statewide criminal background check by an agency authorized by the Office of State Police to conduct criminal background checks on all staff that was conducted within 90 days prior to hire or employment; or
- b. request a criminal background check on all staff prior to hire or employment in the manner required by R.S. 15:587.1 et seq.

2. For any provider that is treating adults, the provider shall obtain a statewide criminal background check on all unlicensed direct care staff within 90 days prior to hire or employment by an agency authorized by the Office of State Police to conduct criminal background checks. The background check shall be conducted within 90 days prior to hire or employment.

3. A provider that hires a contractor to perform work which does not involve any contact with clients is not required to conduct a criminal background check on the contractor if accompanied at all times by a staff person when clients are present in the provider.

E. Prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall review the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry.

F. Prohibitions

1. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who:

- a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of a felony involving:
 - i. abuse or neglect of a person;
 - ii. an alcohol or drug offense, unless the employee or contractor has:
 - (a) completed his/her court-ordered sentence, including community service, probation and/or parole; and
 - (b) been sober per personal attestation for at least the last 2 years;
 - iii. any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;
 - iv. misappropriation of property belonging to another person when:
 - (a) the offense was within the last five years; or
 - (b) the employee/contractor has not completed his/her sentence, including, if applicable, probation or parole;
 - v. a crime of violence;
- b. has a finding placed on the Louisiana state nurse aide registry or the Louisiana direct service worker registry.

G. Orientation and Training

1. All staff shall receive orientation. All direct care staff shall receive orientation prior to providing direct client care without supervision.

2. All staff shall receive in-service training:

- a. at least once a year;

b. that complies with the provider's policies and procedures;

c. that is necessary depending on the needs of the clients; and

d. that is specific to the age of the provider's population.

3. The content of the orientation and in-service training shall include the following:

a. confidentiality in accordance with federal and state laws and regulations;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure and reporting relationships;

f. program philosophy;

g. policies and procedures;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and challenges of the client;

k. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

l. telephone crisis mitigation for those staff members who provide such services;

m. client's rights;

n. duties and responsibilities of each employee;

o. standards of conduct required by the provider;

p. information on the disease process and expected behaviors of clients;

q. maintaining a clean, healthy and safe environment;

r. infectious diseases and universal precautions; and

s. basic emergency care for accidents and emergencies until emergency medical personnel can arrive at provider.

4. The orientation and in-service training shall:

a. be provided only by staff who are qualified by education, training, and qualifying experience; and

b. includes documentation of demonstrated competency of direct care staff, ongoing and prior to providing services to clients.

5. The in-service trainings shall serve as a refresher for subjects covered in orientation or training as indicated through the QI process.

I. The provider shall document an annual staff performance evaluation of all employees.

J. The provider shall report violations of laws, rules, and professional and ethical codes of conduct by provider staff and volunteers to the appropriate professional board or licensing authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1699 (September 2015).

§5643. Core Staffing Personnel Qualifications and Responsibilities

A. All BHS providers shall abide by the following minimum core staffing requirements and shall meet the additional requirements. All BHS providers shall also meet the additional requirements for each specialized program or module pursuant to the provisions of this Chapter as applicable to each BHS provider.

B. Professional Staffing Standards. All BHS providers shall, at a minimum, have the following staff:

1. a medical director who:

a. is a physician with a current, unrestricted license to practice medicine in the state of Louisiana;

b. has the following assigned responsibilities:

i. ensures that the necessary services are provided to meet the needs of the clients;

ii. provides oversight for provider policy/procedure and staff regarding the medical needs of the clients according to the current standards of medical practice;

iii. directs the specific course of medical treatment for all clients;

iv. reviews reports of all medically related accidents/incidents occurring on the premises and identify hazards to the administrator;

v. participates in the development and implementation of policies and procedures for the delivery of services;

vi. periodically reviews delivery of services to ensure care meets the current standards of practice; and

vii. participates in the development of new programs and modifications;

c. has the following responsibilities or designates the duties to a qualified practitioner:

i. writes the admission and discharge orders;

ii. writes and approves all prescription medication orders;

iii. develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;

iv. provides consultative and on-call coverage to ensure the health and safety of clients; and

v. collaborates with the client's primary care physician and psychiatrists as needed for continuity of the client's care;

2. an administrator who:

a. has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates adequate knowledge, experience and expertise in business management;

b. is responsible for the on-site day to day operations of the BHS provider and supervision of the overall BHS provider's operation commensurate with the authority conferred by the governing body; and

c. shall not perform any programmatic duties and/or make clinical decisions unless licensed to do so;

3. with the exception of opioid treatment programs, a clinical supervisor who:

a. is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;

b. shall be on duty and on call as needed;

c. has two years of qualifying clinical experience as an LMHP in the provision of services provided by the provider;

d. shall have the following responsibilities:

i. provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;

ii. serve as resource person for other professionals counseling persons with behavioral health disorders;

iii. attend and participate in care conferences, treatment planning activities, and discharge planning;

iv. provide oversight and supervision of such activities as recreation, art/music, or vocational education;

v. function as client advocate in treatment decisions;

vi. ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;

vii. provide only those services that are within the person's scope of practice; and

viii. assist the medical director and governing body with the development and implementation of policies and procedures;

4. nursing staff who:

a. provide the nursing care and services under the direction of a registered nurse necessary to meet the needs of the clients; and

b. have a valid current nursing license in the State of Louisiana.

i. A BHS provider with clients who are unable to self-administer medication shall have a sufficient number of nurses on staff to meet the medication needs of its clients.

ii. Nursing services may be provided directly by the BHS or may be provided or arranged via written contract, agreement, policy, or other document. The BHS shall maintain documentation of such arrangement.

C. Other Staffing Requirements. The provider shall abide by the following staffing requirements that are applicable to its provider:

1. Licensed Mental Health Professionals

a. The provider shall maintain a sufficient number of LMHPs to meet the needs of its clients.

b. The LMHP has the following responsibilities:

i. provide direct care to clients utilizing the core competencies of addiction counseling and/or mental health counseling and may serve as primary counselor to specified caseload;

ii. serve as resource person for other professionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities, and discharge planning;

iv. provide on-site and direct professional supervision of any unlicensed professional or inexperienced professional;

v. function as the client's advocate in all treatment decisions affecting the client; and

vi. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, discharge, etc.).

2. Unlicensed Professionals

a. The provider shall maintain a sufficient number of unlicensed professionals (UPs) to meet the needs of its clients.

b. The UP shall:

i. provide direct care to clients and may serve as primary counselor to specified caseload under clinical supervision;

ii. serve as resource person for other professionals and paraprofessionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities and discharge planning;

iv. function as the client's advocate in all treatment decisions affecting the client; and

v. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, etc.).

3. Direct Care Aides

a. A residential provider shall have a sufficient number of direct care aides to meet the needs of the clients.

b. A provider that provides outpatient services shall use direct care aides as needed.

c. Direct care aides shall meet the following minimum qualifications:

i. has obtained a high school diploma or equivalent;

ii. be at least 18 years old in an adult provider and 21 years old in a provider that treats children and/or adolescents.

d. Direct care aides shall have the following responsibilities:

i. ensure a safe environment for clients;

ii. exercise therapeutic communication skills;

iii. take steps to de-escalate distressed clients;

iv. observe and document client behavior;

v. assist with therapeutic and recreational activities;

vi. monitor clients' physical well-being;

vii. provide input regarding patient progress to the interdisciplinary team;

viii. oversee the activities of the facility when there is no professional staff on duty;

ix. possess adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed; and

x. function as client advocate.

4. Volunteers

a. If a BHS provider utilizes volunteers, the provider shall ensure that each volunteer is:

i. supervised to protect clients and staff;

ii. oriented to the provider, job duties, and other pertinent information;

iii. trained to meet requirements of duties assigned;

iv. given a written job description or written agreement;

v. identified as a volunteer;

- vi. trained in privacy measures;
- vii. required to sign a written confidentiality agreement; and
- viii. required to submit to a statewide criminal background check by an agency authorized by the Office of the State Police to conduct criminal background checks prior to providing direct care.

b. If a BHS provider utilizes student volunteers, it shall ensure that each student volunteer:

- i. has current registration with the applicable Louisiana professional board, when required, and is in good standing at all times that is verified by the provider;
- ii. is actively pursuing a degree in a human service field or professional level licensure or certification at all times;
- iii. provides direct client care utilizing the standards developed by the professional board;
- iv. provides care only under the direct supervision of the appropriate supervisor; and
- v. provides only those services for which the student has been trained and deemed competent to perform.

c. A volunteer's duties may include:

- i. direct care activities only when qualified provider personnel are present;
- ii. errands, recreational activities; and
- iii. individual assistance to support services.

d. The provider shall designate a volunteer coordinator who:

- i. has the experience and training to supervise the volunteers and their activities; and
- ii. is responsible for selecting, evaluating and supervising the volunteers and their activities.

5. Care Coordinator

a. The provider shall ensure that each care coordinator:

- i. has a high school diploma or equivalent;
- ii. is at least 18 years old in an adult provider and 21 years old in provider that treats children and/or adolescents; and
- iii. has been trained to perform assigned job duties.

E. Multiple Positions. If a BHS provider employs a staff member in more than one position, the provider shall ensure that:

- 1. the person is qualified to function in both capacities; and
- 2. one person is able to perform the responsibilities of both jobs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1700 (September 2015).

§5645. Personnel Records

A. A BHS provider shall maintain a personnel file for each employee and direct care staff member. Each record shall contain:

- 1. the application for employment and/or resume, including contact information and employment history for the preceding five years, if applicable;
- 2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations or health screens;

4. evidence of current applicable credentials/certifications for the position;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to allegations of abuse, neglect and misappropriation of clients' funds;

7. the employee's starting and termination dates;

8. proof of attendance of orientation, training and in-services;

9. results of statewide criminal background checks by an agency authorized by the Office of State Police to conduct criminal background checks on all direct care staff;

10. job descriptions and performance expectations;

11. prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall have documentation of reviewing the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry; and

12. a written confidentiality agreement signed by the staff upon hire and subsequently per provider's policy.

B. A BHS provider shall retain personnel files for at least three years following termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1702 (September 2015).

Subchapter F. Admission, Transfer and Discharge

§5647. Admission Requirements

A. A BHS provider shall not refuse admission to any individual on the grounds of race, religion, national origin, sexual orientation, ethnicity or disability.

B. A BHS provider shall admit only those individuals whose behavioral health needs, pursuant to the Initial Admission Assessment, can be fully met by the provider.

C. Pre-Admission Requirements

1. Prior to admission, the provider shall either:

- a. conduct an initial admission assessment; or
- b. obtain a current assessment conducted within the past year that determines the individual's diagnosis and update the assessment to represent the client's current presentation.

2. If the client is disoriented due to psychological or physiological complications or conditions, the initial admission assessment shall be completed as soon as the client is capable of participating in the process.

3. The BHS provider shall include client participation in the assessment process to the extent appropriate.

4. The initial admission assessment shall contain the following:

- a. a screening to determine eligibility and appropriateness for admission and referral;
- b. a biopscho-social evaluation that includes:
 - i. circumstances leading to admission;
 - ii. past and present behavioral health concerns;
 - iii. past and present psychiatric and addictive disorders treatment;
 - iv. significant medical history and current health status;

- v. family and social history;
- vi. current living situation;
- vii. relationships with family of origin, nuclear family, and significant others;
- viii. education and vocational training;
- ix. employment history and current status;
- x. military service history and current status;
- xi. legal history and current legal status;
- xii. emotional state and behavioral functioning, past and present; and
- xiii. strengths, weaknesses, and needs;
- c. physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process;
- d. drug screening when history is inconclusive or unreliable;
- e. appropriate assignment to level of care with referral to other appropriate services as indicated;
- f. signature and date by the LMHP; and
- g. for residential facilities, diagnostic laboratory tests or appropriate referral as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.

D. Admission Requirements

1. A provider shall establish admission requirements that include:
 - a. availability of appropriate physical accommodations;
 - b. legal authority or voluntary admission;
 - c. availability of professionals to provide services needed as indicated by the initial assessment and diagnosis; and
 - d. written documentation that client and family, if applicable, consents to treatment and understands the diagnosis and level of care.
2. Client/Family Orientation. Each provider shall ensure that a confidential and efficient orientation is provided to the client and the client's family, if applicable, concerning:
 - a. visitation in a residential facility, if applicable;
 - b. family involvement;
 - c. safety;
 - d. the rules governing individual conduct;
 - e. authorization to provide treatment;
 - f. adverse reactions to treatment;
 - g. the general nature and goals of the program;
 - h. proposed treatment to include treatment methodology, duration, goals and services;
 - i. risks and consequences of non-compliance;
 - j. treatment alternatives;
 - k. clients rights and responsibilities; and
 - l. all other pertinent information, including fees and consequences of non-payment of fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1702 (September 2015).

§5649. Transfer and Discharge Requirements

- A. Each provider shall develop, implement and comply with policies and procedures that address:
 1. discharge;
 2. transition to another level of care; and
 3. transfer to another licensed provider.
- B. The BHS provider shall ensure that a client is discharged:
 1. when the client's treatment goals are achieved, as documented in the client's treatment plan;
 2. when the client's issues or treatment needs are not consistent with the services the provider is authorized or able to provide;
 3. according to the provider's established written discharge criteria; or
 4. when the voluntarily-admitted client, or client's parent or legal guardian, if applicable, requests discharge.
- C. Discharge planning shall begin upon admission.
- D. Discharge Plan. The provider shall submit a written discharge plan to each client upon discharge or, if unable to submit at discharge, within seven days after discharge. The discharge plan shall provide reasonable protection of continuity of services that includes:
 1. the client's transfer or referral to outside resources, continuing care appointments, and crisis intervention assistance;
 2. documented attempts to involve family or an alternate support system in the discharge planning process;
 3. the client's goals or activities to sustain recovery;
 4. signature of the client or, if applicable, the client's parent or guardian;
 5. name, dosage, route and frequency of client's medications ordered at the time of discharge; and
 6. the disposition of the client's possessions, funds and/or medications, if applicable.
- E. Discharge Summary. The BHS provider shall ensure that each client record contains a written discharge summary that includes:
 1. the client's presenting needs and issues identified at the time of admission;
 2. the services provided to the client;
 3. the provider's assessment of the client's progress towards goals;
 4. the discharge disposition; and
 5. the continuity of care recommended following discharge, supporting documentation and referral or transfer information.
- F. When a request for discharge is received or when the client leaves the provider against the provider's advice, the provider shall:
 1. have and comply with written procedures for handling discharges and discharge requests;
 2. document the circumstances surrounding the leave; and
 3. complete the discharge summary within 30 days of the client's leaving the program or sooner for continuity of care.

G. Transitions. When a client undergoes a transition to another level of care, the provider shall ensure that:

1. the transition to a different level of care is documented in the client's record by a member of the direct care staff;
2. the client is notified of the transition; and
3. if transitioning to a different provider, the staff coordinates transition to next level of care.

H. Transfer Process

1. If a residential provider decides to transfer a client, the provider shall ensure that there is an agreement with the receiving provider to provide continuity of care based on:

- a. the compilation of client data; or
- b. the medical history/examination/physician orders, psycho-social assessment, treatment plan, discharge summary and other pertinent information provided upon admission to inpatient or outpatient care.

2. The residential provider responsible for the transfer and discharge of the client shall:

- a. request and receive approval from the receiving provider prior to the transfer;
- b. notify the receiving provider prior to the arrival of the client of any significant medical and/or psychiatric conditions and complications or any other pertinent information that will be needed to care for the client prior to arrival;
- c. transfer all requested client information and documents upon request; and
- d. ensure that the client has consented to the transfer.

I. If a client is involuntarily committed to a provider, the provider shall:

1. maintain the care of the client until an appropriate level of care becomes available; and
2. comply with the transfer and discharge requirements in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1703 (September 2015).

Subchapter G. Services

§5651. Treatment Protocols

A. A BHS provider shall deliver all services according to a written plan that:

1. is age and culturally appropriate for the population served;
2. demonstrates effective communication and coordination;
3. provides utilization of services at the appropriate level of care;
4. is an environment that promotes positive well-being and preserves the client's human dignity; and
5. utilizes evidence-based counseling techniques and practices.

B. The provider shall make available a variety of services, including group and/or individual treatment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015).

§5653. Treatment Plan

A. Each client of the BHS provider shall have a treatment plan linked to the assessment that contains:

1. documented input from the counselor and client within 72 hours after admission to a residential facility, with information from other disciplines added as the client is evaluated and treated;
2. client-specific, measurable goals that are clearly stated in behavioral terms;
3. the treatment modalities to be utilized;
4. realistic and specific expected achievement dates;
5. the strategies and activities to be used to help the client achieve the goals;
6. information specifically related to the mental, physical, and social needs of the client; and
7. the identification of staff assigned to carry out the treatment.

B. The BHS provider shall ensure that the treatment plan is in writing and is:

1. developed in collaboration with the client and when appropriate, the client's family and is signed by the client or the client's family, when appropriate;
2. reviewed and revised as required by this Chapter or more frequently as indicated by the client's needs;
3. consistently implemented by all staff members;
4. signed by the LMHP or physician responsible for developing the treatment plan; and
5. is in language easily understandable to the client and to the client's family, when applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015).

§5655. Core Services

A. A BHS provider shall provide the following services to its clients when needed:

1. assessment;
2. orientation;
3. treatment;
4. client education;
5. consultation with professionals;
6. counseling services;
7. referral;
8. medication management;
9. rehabilitation services; and
10. crisis mitigation.

B. Crisis Mitigation Services

1. The BHS provider's crisis mitigation plan shall:
 - a. identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and
 - b. specify names and telephone numbers of staff or organizations to assist clients in crisis.

2. If the provider contracts with another entity to provide crisis mitigation services, the BHS provider shall have a written contract with the entity providing the crisis mitigation services.

3. The qualified individual, whether contracted or employed by the BHS provider, shall call the client within 30 minutes of receiving notice of the client's call.

C. Referral

1. The provider shall provide:
 - a. appropriate resource information regarding local agencies to client and family, if applicable, upon need or request; and
 - b. procedures to access vocational services, community services, transitional living services and transportation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015).

§5657. Laboratory Services

A. Each BHS provider that provides medication management and/or addiction treatment services shall:

1. have a written agreement for laboratory services off-site or provide laboratory services on-site;
2. ensure that the laboratory providing the services has current clinical laboratories improvement amendments (CLIA) certification when necessary;
3. ensure diagnostic laboratory services are available to meet the behavioral health needs of the clients; and
4. maintain responsibility for all laboratory services provided on-site or off-site via contractual agreement.

B. If collection is performed on-site, the provider shall develop, implement and comply with written policies and procedures for the collection of specimens in accordance with current standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1705 (September 2015).

§5659. Medications

A. A BHS provider that stores stock medications of scheduled controlled dangerous substances shall maintain:

1. a site-specific Louisiana controlled dangerous substance license in accordance with the Louisiana Uniform Controlled Dangerous Substance Act; and
2. a United States Drug Enforcement Administration controlled substance registration for the provider in accordance with title 21 of the *United States Code*.

B. The provider, when applicable, shall develop, implement and comply with written policies and procedures that govern:

1. the safe administration and handling of all prescription and nonprescription medications;
2. identification of medications being brought into the premises when the provider is responsible for administering medications;
3. the storage, dispensing, if applicable, and recording and control of all medications;
4. The self-administration of all medications, that includes:
 - a. age limitations for self-administration;
 - b. order from the authorized licensed prescriber;
 - c. parental consent, if applicable; and
 - d. the manner in which the client is monitored by staff to ensure medication is taken as prescribed in the treatment plan;
5. the disposal of all discontinued and/or expired medications and containers with worn, illegible or missing

labels in accordance with state and federal law and regulations;

6. the use of prescription medications including:
 - a. when medication is administered and monitoring of the effectiveness of the medication administered;
 - b. a procedure to inform clients, staff, and where appropriate, client's parent(s) or legal guardian(s) of each medication's anticipated results, the potential benefits and side-effects as well as the potential adverse reaction that could result from not taking the medication as prescribed;
 - c. involving clients and, when appropriate, their parent(s) or legal guardian(s) in decisions concerning medication; and
 - d. staff training to ensure the recognition of the potential side effects of the medication;
7. recording of medication errors and adverse drug reactions and reporting them to the client's physician or authorized prescriber;
8. the reporting of and steps to be taken to resolve discrepancies in inventory, misuse and abuse of controlled dangerous substances in accordance with federal and state law; and
9. reconciliation of all controlled dangerous substances to guard against diversion.

C. The provider shall ensure that:

1. any medication administered to a client is administered as prescribed;
2. all medications are kept in a locked cabinet, closet or room and under recommended temperature controls;
3. all controlled dangerous substances shall be kept separately from other medications in a locked cabinet or compartment accessible only to individuals authorized to administer medications;
4. current and accurate records are maintained on the receipt and disposition of all scheduled drugs;
5. schedule II, III and IV of the provider's controlled dangerous substances are reconciled at least twice a day by different shifts of staff authorized to administer controlled dangerous substances;
6. medications are administered only upon receipt of written orders by paper, facsimile, or electronic transmission, or verbal orders from an authorized licensed prescriber;
7. all verbal orders are signed by the authorized licensed prescriber within 10 calendar days;
8. medications that require refrigeration are stored in a refrigerator or refrigeration unit separate from food, beverages, blood, and laboratory specimens;
9. all prescription medications are labeled to identify:
 - a. the client's full name;
 - b. the name of the medication;
 - c. dosage;
 - d. quantity and date dispensed;
 - e. directions for taking the medication;
 - f. required accessory and cautionary statements;
 - g. prescriber's name; and
 - h. the expiration date, if applicable;
10. medication errors, adverse drug reactions, and interactions with other medications, food or beverages taken by the client are immediately reported to the medical director with an entry in the client's record; and

11. discrepancies in inventory of controlled dangerous substances are reported to the pharmacist.

D. BHS Providers that Dispense Medications

1. If the BHS provider dispenses medications to its clients, the provider shall:

- a. provide pharmaceutical services on-site at the center; or
- b. have a written agreement with a pharmaceutical provider to dispense the medications.

2. The provider shall ensure that all compounding, packaging, and dispensing of medications is:

- a. accomplished in accordance with Louisiana law and Board of Pharmacy regulations; and
- b. performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1705 (September 2015).

Subchapter H. Client Rights

§5661. Client Rights

A. The BHS provider shall develop, implement and comply with policies and procedures that:

1. protect its client's rights;
2. respond to questions and grievances pertaining to these rights;
3. ensure compliance with client's rights enumerated in R.S. 28:171; and
4. ensure compliance with minor's rights enumerated in the *Louisiana Children's Code* article 1409.

B. A BHS provider's client and, if applicable, the client's parent(s) or legal guardian, have the following rights:

1. to be informed of the client's rights and responsibilities at the time of admission or within 24 hours of admission;
2. to have a family member, chosen representative and/or his or her own physician notified of admission to the BHS provider at the request of the client;
3. to receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, or disability;
4. to maintain the personal dignity of each client;
5. to be free from abuse, neglect, exploitation and harassment;
6. to receive care in a safe setting;
7. to receive the services of a translator or interpreter, if applicable, to facilitate communication between the client and the staff;
8. to be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan;
9. to make informed decisions regarding the client's care by the client or the client's parent or guardian, if applicable, in accordance with federal and state laws and regulations;
10. to participate or refuse to participate in experimental research when the client gives informed, written consent to such participation, or when a client's parent or legal guardian provides such consent, when applicable, in accordance with federal and state laws and regulations;

11. for clients in residential facilities, to consult freely and privately with the client's legal counsel or to contact an attorney at any reasonable time;

12. to be informed, in writing, of the policies and procedures for filing a grievance and their review and resolution;

13. to submit complaints or grievances without fear of reprisal;

14. for clients in residential facilities, to possess and use personal money and belongings, including personal clothing, subject to rules and restrictions imposed by the BHS provider;

15. for clients in residential facilities, to visit or be visited by family and friends subject to rules imposed by the provider and to any specific restrictions documented in the client's treatment plan;

16. to have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations;

17. for clients in residential facilities, access to indoor and outdoor recreational and leisure opportunities;

18. for clients in residential facilities, to attend or refuse to attend religious services in accordance with his/her faith;

19. to be given a copy of the program's rules and regulations upon admission;

20. to receive treatment in the least restrictive environment that meets the client's needs;

21. to not be restrained or secluded in violation of federal and state laws, rules and regulations;

22. to be informed in advance of all estimated charges and any limitations on the length of services at the time of admission or within 72 hours;

23. to receive an explanation of treatment or rights while in treatment;

24. to be informed of the:
- a. nature and purpose of any services rendered;
 - b. the title of personnel providing that service;
 - c. the risks, benefits, and side effects of all proposed treatment and medications;
 - d. the probable health and mental health consequences of refusing treatment; and
 - e. other available treatments which may be appropriate;

25. to accept or refuse all or part of treatment, unless prohibited by court order or a physician deems the client to be a danger to self or others or gravely disabled;

26. for children and adolescents in residential BH facilities, to access educational services consistent with the client's abilities and needs, relative to the client's age and level of functioning; and

27. to have a copy of these rights, which includes the information to contact HSS during routine business hours.

C. The residential or outpatient clinic provider shall

1. post a copy of the clients' rights on the premises that is accessible to all clients; and
2. give a copy of the clients' rights to each client upon admission and upon revision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1706 (September 2015).

§5663. Grievances

A. The provider shall develop, implement and comply with a written grievance procedure for clients designed to allow clients to submit a grievance without fear of retaliation. The procedure shall include, but not be limited to:

1. a procedure for filing a grievance;
2. a time line for responding to the grievance;
3. a method for responding to a grievance; and
4. the staff's responsibilities for addressing grievances.

B. The provider shall ensure that:

1. the client and, if applicable, the client's parent(s) or legal guardian(s), is informed of the grievance procedure; and
2. all grievances are addressed and resolved to the best of the provider's ability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

Subchapter I. Physical Environment

§5665. Exterior Space Requirements

A. The provider shall maintain its exterior areas that are accessible to the clients, including the grounds and structures on the grounds, in good repair and free from potential hazards to health or safety.

B. The provider shall ensure the following:

1. garbage stored outside is secured in noncombustible, covered containers and removed on a regular basis;
2. trash collection receptacles and incinerators are separate from recreation areas;
3. unsafe areas have safeguards to protect clients from potential hazards;
4. fences are in good repair;
5. exterior areas are well lit; and
6. the provider has signage that indicates the provider's:
 - a. legal or trade name;
 - b. address;
 - c. hours of operation; and
 - d. telephone number(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

§5667. Interior Space for Residential Facilities and Outpatient Clinics

A. The BHS provider that provides services on-site shall:

1. have a physical environment that ensures the health, safety and security of the clients;
2. have routine maintenance and cleaning services;
3. be well-lit, clean, safe and ventilated;
4. maintain its physical environment, including, but not limited to, all equipment, fixtures, plumbing, electrical, furnishings, doors and windows, in good order and safe

condition and in accordance with manufacturer's recommendations; and

5. maintain heating, ventilation and cooling systems in good order and safe condition to ensure a temperature controlled environment.

B. The provider shall have designated space for the secure storage of the staff's personal belongings.

C. Furnishings. The BHS provider shall ensure that the provider's furnishings for all living and treatment areas are designed to meet the needs of the clients.

D. Medication Storage and Preparation. The provider shall have an area for medication preparation, administration and storage that meets one of the following:

1. a secured medication room that contains sufficient space for a work counter, sink, refrigerator, locked storage for controlled dangerous substances; or
2. a secured self-contained medication distribution unit located in a clean workroom, alcove or other staff work area with an easily accessible hand washing station.

E. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from the client living and/or treatment areas that serves as an administrative office.

2. The provider shall have a designated space(s) to allow for private and group discussions and counseling sessions.

F. Smoking. The provider shall prohibit smoking in the interior of its licensed space.

G. Bathrooms

1. There shall be at least one bathroom for use by clients and staff and meets the requirements of the Louisiana *Sanitary Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

§5669. Interior Space for Residential Facilities

A. The provider shall evaluate each client's physical, emotional and medical needs and the physical environment of the facility in order to ensure the safety and well-being of all admitted clients.

B. Common Area. The facility's physical environment shall have a designated space accessible to the clients:

1. to be used for group meetings, dining, visitation, leisure and recreational activities;
2. that is at least 25 square feet per client and no less than 150 square feet, exclusive of bedrooms or sleeping areas, bathrooms, areas restricted to staff, laundry rooms and office areas; and
3. that contains a sufficient number of tables and chairs for eating meals.

C. The facility's physical environment shall have a designated room(s) or area(s) to allow for private and group discussions and counseling sessions that:

1. safely accommodates the clients being served;
2. has adequate space to meet the client's needs in the therapeutic process; and
3. is exclusive of bedrooms, bathrooms and common areas.

D. Client Bedrooms. The provider shall ensure that each client bedroom in the facility:

1. contains at least 80 square feet for single bedrooms, exclusive of fixed cabinets, fixtures and equipment;
2. contains at least 60 square feet per bed for multi-bedrooms, exclusive of fixed cabinets, fixtures, and equipment;
3. has at least a 7 1/2 foot ceiling height over the required area except in a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space;
4. has at least 2 foot minimum clearance at the foot of each bed; and
5. contains no more than four beds;
 - a. exception. Providers licensed as substance abuse/addiction treatment residential facilities at the time this Rule is promulgated that have more than four clients per bedroom, may maintain the existing bedroom space that allows more than four clients per bedroom provided that the bedroom space has been previously approved by DHH waiver. This exception applies only to the currently licensed physical location;
6. has at least three feet between beds;
7. has designated storage space for the client's:
 - a. clothes;
 - b. toiletries; and
 - c. personal belongings;
8. has a screened window that opens to the outside;
9. has sheets, pillow, bedspread and blankets for each client that are clean and in good repair and discarded when no longer usable;
10. has sufficient headroom to allow the occupant to sit up; and
11. contains a bed(s) that:
 - a. is longer than the client is tall;
 - b. is no less than 30 inches wide;
 - c. is of solid construction;
 - d. has a clean, comfortable, nontoxic fire retardant mattress; and
 - e. is appropriate to the size and age of the client.

E. The provider shall:

1. prohibit any client over the age of five years to occupy a bedroom with a member of the opposite sex who is not in the client's immediate family;
2. require separate bedrooms and bathrooms for adults, and children/adolescents, except in the Mothers with Dependent Children Program, and for males and females;
3. prohibit adults and children/adolescents from sharing the same space, except in the Mothers with Dependent Children Program;
4. require sight and sound barriers between adult area/wing and the adolescent area/wing;
5. for facilities with child/adolescent clients, ensure that the age of clients sharing bedroom space is not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan or the behavioral health assessment of the client;
6. ensure that each client has his/her own bed;
7. prohibit mobile homes from being used as client sleeping areas; and
8. prohibit bunk beds in the following programs:

- a. clinically managed residential detoxification (ASAM level III.2D);
- b. Clinically Managed High Intensity Residential Program (ASAM level III.5);
- c. medically monitored intensive residential treatment (ASAM level III.7); and
- d. medically monitored residential detoxification (ASAM level III.7D).

F. Bathrooms

1. In accordance with the Louisiana state *Sanitary Code*, a provider shall have bathrooms equipped with lavatories, toilets, tubs and/or showers for use by the clients located within the provider and the following:

- a. shatterproof mirrors secured to the walls at convenient heights; and
- b. other furnishings necessary to meet the clients' basic hygienic needs.

2. The provider shall have the ratio of lavatories, toilets, tubs and/or showers to clients required by the Louisiana state *Sanitary Code*.

3. A provider shall have at least one separate toilet, lavatory, and bathing facility for the staff located within the provider.

4. In a multi-level facility, there shall be at least one a full bathroom with bathing facility reserved for client use on each client floor.

5. Each bathroom shall be located so that it opens into a hallway, common area or directly into the bedroom. If the bathroom only opens directly into a bedroom, it shall be for the use of the occupants of that bedroom only.

6. The provider shall ensure that each client has personal hygiene items, such as a toothbrush, toothpaste, shampoo, and soap as needed.

H. Kitchen

1. If a BHS provider prepares meals on-site, the BHS provider shall have a full service kitchen that meets the requirements of the Louisiana state *Sanitary Code* and:

- a. includes a cooktop, oven, refrigerator, freezer, hand washing station, storage and space for meal preparation;

- b. is inspected and approved annually by OPH;

- c. has the equipment necessary for the preparation, serving, storage and clean-up of all meals regularly served to all of the clients and staff; and

- d. contains trash containers covered and made of metal or United Laboratories-approved plastic;

2. A BHS provider that does not prepare meals on-site shall have a nourishment station or a kitchenette, that includes:

- a. a sink;

- b. a work counter;

- c. a refrigerator;

- d. storage cabinets;

- e. equipment for preparing hot and cold nourishments between scheduled meals; and

- f. space for trays and dishes used for nonscheduled meal service.

I. Laundry. The provider shall have a laundry space complete with a ratio of 1:20 washers and dryers to meet the needs of the clients.

J. Staff Quarters. The provider utilizing live-in staff shall provide adequate, separate living space with a private bathroom for staff usage only.

K. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

L. The provider shall ensure that outside doors and windows prohibit an outsider from gaining unauthorized ingress.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

Subchapter J. Safety and Emergency Preparedness

§5671. Safety Provisions for Outpatient Clinics and Residential Facilities

A. The provider shall provide additional supervision when necessary to provide for the safety of all individuals.

B. The provider shall:

1. prohibit weapons of any kind on-site unless possessed by security or law enforcement official or hired security while in uniform and on official business;

2. ensure that its equipment, furnishings, accessories and any other items that are in a state of disrepair or defects are removed and inaccessible until replaced or repaired;

3. ensure that all poisonous, toxic and flammable materials are:

a. maintained in appropriate containers and labeled as to the contents;

b. securely stored in a separate and locked storage area that is inaccessible to clients;

c. maintained only as necessary; and

d. are used in such a manner as to ensure the safety of clients, staff and visitors;

4. ensure that supervision and training is provided to any staff member or client exposed to or that may come in contact with potentially harmful materials such as cleaning solvents and/or detergents;

5. ensure that a first aid kit is readily available in the provider and in all vehicles used to transport clients.

C. Required Inspections. The provider shall be in compliance with all required inspections and shall have documentation to demonstrate compliance with applicable laws and regulations.

D. The provider shall have an on-going safety program in any facility where clients, staff and others may be, that includes:

1. continuous inspection of the provider for possible hazards;

2. continuous monitoring of safety equipment and maintenance or repair when needed;

3. investigation and documentation of all accidents or emergencies; and

4. fire control and evacuation planning with documentation of all emergency drills.

E. Required BHS Provider Reporting. The provider shall report the following incidents in writing to HSS on the HSS approved form within 24 hours of discovery:

1. any disaster or emergency or other unexpected event that causes significant disruption to program operations and an inability to provide services for greater than 24 hours;

2. any death or serious injury of a client that:

a. may potentially be related to program activities; or

b. at the time of his/her death or serious injury, was on-site at the BHS provider's premises or a resident of the provider's facility; and

3. allegations of client abuse, neglect and/or exploitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1709 (September 2015).

§5673. Infection Control

A. The provider shall provide a sanitary environment to avoid source(s) and transmission of infections and communicable diseases.

B. The provider shall have an active Infection Control Program that requires:

1. reporting of infectious disease in accordance with CDC and state OPH guidelines;

2. monitoring of:

a. the spread of infectious disease;

b. hand washing;

c. staff and client education; and

d. incidents of specific infections in accordance with OPH guidelines;

3. corrective actions; and

4. a designated infection control coordinator who:

a. develops and implements policies and procedures related to infection control; and

b. has training and/or experience in infection control;

5. universal precautions; and

6. strict adherence to all sanitation requirements.

C. The provider shall maintain a clean and sanitary environment and shall ensure that:

1. supplies and equipment are available to staff;

2. consistent ongoing monitoring and cleaning of all areas of the provider;

3. methods used for cleaning, sanitizing, handling and storing of all supplies and equipment prevent the transmission of infection;

4. procedures are posted for sanitizing kitchen, kitchen, bathroom and laundry areas in accordance with the *Louisiana Sanitary Code*; and

5. storage, handling, and removal of food and waste will not spread disease, cause noxious odor, or provide a breeding place for pests.

D. The provider may enter into a written contract for housekeeping services necessary to maintain a clean and neat environment.

E. The provider shall have an effective pest control plan.

F. After discharge of a client, the residential provider shall:

1. clean the bed, mattress, cover, bedside furniture and equipment;

2. ensure that mattresses, blankets and pillows assigned to clients are in sanitary condition; and

3. ensure that the mattress, blankets and pillows used for a client with an infection is sanitized before assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1709 (September 2015).

§5675. Emergency Preparedness

A. The BHS provider shall have a written emergency preparedness plan:

1. to maintain continuity of the provider's operations in preparation for, during and after an emergency or disaster;
2. to manage the consequences of all disasters or emergencies that disrupt the provider's ability to render care and treatment, or threaten the lives or safety of the clients; and
3. that is prepared in coordination with the provider's local and/or parish Office of Homeland Security and Emergency Preparedness (OHSEP).

B. The residential facility or outpatient clinic provider shall:

1. post floor plans with diagrams giving clear directions on how to exit the building safely and in a timely manner at all times;
2. post emergency numbers by all telephones;
3. have a separate floor plan or diagram with designated safe zones or sheltering areas for non-fire emergencies; and
4. train its employees in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for each employee and on each shift.

C. The residential BHS provider's emergency preparedness plan shall include, at a minimum:

1. in the event of an emergency, an assessment of all clients to determine the clients:
 - a. who continue to require services and should remain in the care of the provider; or
 - b. who may be discharged to receive services from another provider;
2. the determination as to when the facility will shelter in place and when the facility will evacuate for a disaster or emergency and the conditions that guide these determinations in accordance with local or parish OHSEP;
3. provisions for when the provider shelters-in-place that include:
 - a. the decision to take this action is made after reviewing all available and required information on the emergency/disaster, the provider, the provider's surroundings, and consultation with the local or parish OHSEP;
 - b. provisions for seven days of necessary supplies to be provided by the provider prior to the emergency, including drinking water or fluids and non-perishable food; and
 - c. the delivery of essential services to each client;
4. provisions for when the provider evacuates with clients:
 - a. the delivery of essential provisions and services to each client, whether the client is in a shelter or other location;
 - b. the provider's method of notifying the client's family or caregiver, including:
 - i. the date and approximate time that the Provider or client is evacuating;

- ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

- iii. a telephone number that the family or responsible representative may call for information regarding the client's evacuation;

- c. provisions for ensuring that supplies, medications, clothing and a copy of the treatment plan are sent with the client, if the client is evacuated;

- d. the procedure or methods that will be used to ensure that identification accompanies the client. The identification shall include the following information:

- i. current and active diagnosis;
 - ii. all medication, including dosage and times administered;
 - iii. allergies;
 - iv. special dietary needs or restrictions; and
 - v. legal representative, if applicable, including contact information;

- e. transportation or arrangements for transportation for an evacuation that is adequate for the current census;

5. provisions for staff to maintain continuity of care during an emergency; and

6. staff distribution and assignment of responsibilities and functions during an emergency.

D. The outpatient clinic's emergency preparedness plan shall include, at a minimum:

1. in the event of an emergency or disaster, an assessment of all clients to determine the clients:

- a. who continue to require services; or
 - b. who may be discharged to receive services from another provider;

2. a plan for each client to continue to receive needed services during a disaster or emergency either by the provider or referral to another program; and

3. measures to be taken to locate clients after an emergency or disaster and determine the need for continued services and/or referral to other programs.

E. The provider shall:

1. follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency;

2. if the state, parish or local OHSEP orders a mandatory evacuation of the parish or the area in which the agency is serving, ensure that all clients are evacuated according to the provider's emergency preparedness plan;

3. review and update its emergency preparedness plan at least once a year;

4. cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and provide information as requested;

5. monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials;

6. upon request by the department, submit a copy of its emergency preparedness plan for review; and

7. upon request by the department, submit a written summary attesting how the emergency plan was followed and executed. The summary shall contain, at a minimum:

- a. pertinent plan provisions and how the plan was followed and executed;
 - b. plan provisions that were not followed;

- c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;
- d. contingency arrangements made for those plan provisions not followed; and
- e. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1710 (September 2015).

§5677. Inactivation of License due to a Declared Disaster or Emergency

A. A licensed BHS provider located in a parish which is the subject of an executive order or proclamation of emergency or disaster issued, may seek to inactivate its license for a period not to exceed one year, provided that the provider:

- 1. submits written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:
 - a. the BHS provider has experienced an interruption in the provisions of services and an inability to resume services as a result of events that are the subject of such executive order or proclamation of emergency or;
 - b. the BHS provider intends to resume operation as a BHS provider in the same service area;
 - c. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;
 - d. includes an attestation that all clients have been properly discharged or transferred to another provider; and
 - e. lists the clients and the location of the discharged or transferred clients;
- 2. submits documentation of the provider's interruption in services and inability to resume services as a result of the emergency or disaster;
- 3. resumes operating as a BHS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;
- 4. continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil fines; and
- 5. continues to submit required documentation and information to the department.

B. Upon receiving a completed request to inactivate a BHS provider license, the department may issue a notice of inactivation of license to the BHS provider.

C. In order to obtain license reinstatement, a BHS provider with a department-issued notice of inactivation of license shall:

- 1. submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening that includes:
 - a. the anticipated date of opening, which is within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;
 - b. a request to schedule a licensing survey; and

c. a completed licensing application with appropriate licensing fees and other required documents, if applicable;

2. submit written approvals for occupancy from OSFM and OPH.

D. Upon receiving a completed written request to reinstate a BHS provider license, the department shall conduct a licensing survey.

E. If the BHS provider meets the requirements for licensure and the requirements under this subsection, the department shall issue a notice of reinstatement of the BHS provider license.

F. During the period of inactivation, the department prohibits change of ownership of the provider.

G. The provisions of this Section shall not apply to a BHS provider which has voluntarily surrendered its license.

H. Failure to request inactive status when the license becomes nonoperational due to a disaster or emergency and/or failure to comply with any of the provisions of this subsection shall be deemed a voluntary surrender of the BHS provider license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1711 (September 2015).

Subchapter K. Additional Requirements for Children/Adolescent Programs

NOTE: In addition to the requirements applicable to all Behavioral Health Service providers, programs that treat children and/or adolescents must meet the applicable requirements below.

§5679. General Provisions

A. The BHS provider that provides services to children and/or adolescents shall:

- 1. provide program lectures and written materials to the clients that are age-appropriate and commensurate with their education and skill-level;
- 2. involve the client's family or an alternate support system in the process or document why this is not appropriate;
- 3. prohibit staff from:
 - a. providing, distributing or facilitating access to tobacco products, alcohol or illegal drugs; and
 - b. using tobacco products in the presence of adolescent clients;
- 4. prohibit clients from using tobacco products on the program site or during structured program activities;
- 5. address the special needs of its clients and comply with all applicable standards, laws and protocols to protect their rights;
- 6. develop and implement policies and procedures for obtaining consent in accordance with state statutes; and
- 7. prohibit adults and children/adolescents from attending the same group counseling sessions and activities unless it is therapeutically indicated.

B. Staffing

- 1. All direct care employees shall have training in adolescent development, family systems, adolescent psychopathology and mental health, substance use in adolescents, and adolescent socialization issues.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1711 (September 2015).

§5681. Residential Programs for Children and/or Adolescents

A. Staffing

1. While the clients are on-site, the staff shall:

- a. directly supervise and be readily available within hearing distance of the clients at all times; and
- b. conduct visual checks, including bed checks, at least once every hour, or more frequently as indicated in the treatment plan.

2. The clients who are off-site but under the responsibility of the provider shall be within eyesight of the staff at all times. While off-site, there shall be a ratio of one staff member to five clients.

B. Educational Resources. The provider shall provide a Department of Education-approved opportunity for clients to maintain grade level and continuity of education during any treatment lasting longer than 14 days unless the treatment occurs during school vacation.

C. Family Communications. The provider shall allow regular communication between a client and the client's family and shall not arbitrarily restrict any communications without clear, written, individualized clinical justification documented in the client record.

D. Recreational Space. Clients shall have access to safe, suitable outdoor recreational space and age appropriate equipment that is located, installed and maintained to ensure the safety of the clients.

E. The provider shall provide a tobacco cessation program to assist client's with nicotine dependency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

Subchapter L. Additional Requirements for Mental Health Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides mental health services must meet the requirements of Subchapter L.

§5683. Staffing Requirements

A. Medical Director. The provider with a mental health program shall ensure that its medical director:

- 1. is a physician with two years of qualifying experience in treating psychiatric disorders; or
- 2. is a board-certified psychiatrist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

§5685. Psychosocial Rehabilitation Services

A. The provider that provides psychosocial rehabilitation services (PSR) shall:

- 1. provide PSR either individually or in a group setting;
- 2. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;
- 3. assist the client in developing social and interpersonal skills to:
 - a. increase community tenure;

- b. enhance personal relationships;
- c. establish support networks;
- d. increase community awareness; and
- e. develop coping strategies and effective functioning in the individual's social environment;

4. assist the client with developing daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living;

5. implement learned skills so the client can remain in a natural community location and achieve developmentally appropriate functioning; and

6. assist the client with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

B. Staffing. The provider shall ensure that:

1. the unlicensed professionals providing PSR receive regularly scheduled clinical supervision from an LMHP;

2. the size of group therapy does not exceed 15 adults or 8 adolescents or children;

3. its staff providing PSR services:

- a. is at least 18 years old;
- b. has a high school diploma or equivalent; and
- c. is at least three years older than any individual served under the age of 18.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

§5687. Crisis Intervention

A. Crisis intervention services may occur in a variety of locations including a health care provider or the community.

B. The provider shall ensure that:

1. a preliminary screening of risk, mental status and stability and the need for further evaluation or other mental health services is conducted by an UP that:

- a. includes contact with the client, family members or other collateral sources with pertinent information; and
- b. includes a referral to other alternative mental health services at an appropriate level if necessary;

2. an assessment of risk, mental status and psychiatric stability is conducted by a LMHP.

C. Staffing

1. Unlicensed Professionals

a. Unlicensed professionals (UPs) shall:

i. be at least 20 years old and be at least three years older than a client under the age of 18; and

ii. have either:

(a) an associate's degree in social work, counseling, psychology or a related human services field;

(b) two years of course work in a human services field; or

(c) two years of qualifying experience working with clients who have behavioral health disorders.

b. The responsibilities of the UP include:

i. performing the preliminary screening;

ii. assisting the program's LMHP in conducting the assessment;

iii. developing and implementing an individualized written crisis plan from the assessment that provides procedures to reduce the risks of harm to the client and others as well as follow-up procedures;

- iv. consulting with physician or the program's LMHP when necessary;
 - v. providing short term crisis intervention, including crisis resolution and debriefing with the client;
 - vi. contacting family members when necessary;
- and
- vii. following up with the client and as necessary, with family members and/or caretaker.

2. Licensed Mental Health Professionals

a. The licensed mental health professional (LMHP) shall have experience in administering crisis intervention techniques that work to minimize the risk of harm to self or others.

b. The responsibilities of the LMHP are:

- i. to conduct the assessment of risk, mental status and medical stability;
 - ii. to be available for consultation and support;
- and
- iii. to supervise the development and implementation of each crisis plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

§5689. Community Psychiatric Support and Treatment

A. The provider that provides community psychiatric support and treatment (CPST) services shall:

- 1. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;
- 2. provide CPST services with the client present;
- 3. provide services to minimize the negative effects of the symptoms, emotional disturbances or associated environmental stressors which interfere with the client's daily living;
- 4. provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the client;
- 5. participates in and utilizes strengths-based planning and treatments, that includes identifying strengths and needs, resources, natural supports and developing goals and objectives to address functional deficits associated with the client's mental illness; and
- 6. provides restoration, rehabilitation and support to develop skills to locate, rent and keep a home.

B. Staffing Requirements

1. Unlicensed Professionals Providing CPST Services

a. The program's UPs that provide CPST, except counseling, shall have one of the following:

- i. a bachelor's degree in social work, counseling, psychology or a related human services field;
- ii. four years of equivalent education in a human service field; or
- iii. four years of qualifying experience working with clients who have behavioral health disorders.

b. The program's UPs that provide counseling services shall have a master's degree in social work, counseling, psychology or a related human services field.

c. The responsibilities of the UPs, when providing CPST services include:

- i. assisting the client with effectively responding to or avoiding identified precursors or triggers that would risk the client remaining in a natural community location;
- ii. assisting in the development of daily living skills specific to managing a home; and
- iii. assisting the client and family members to identify strategies or treatment options associated with the client's mental illness.

2. Licensed Mental Health Professionals

a. The LMHP shall have experience in CPST services.

b. The LMHP is responsible for providing clinical supervision of the CPST staff.

3. The provider shall ensure that the direct care staff's caseload size:

- a. is based on the needs of the clients and their families with emphasis on successful outcomes and individual satisfaction; and
- b. meets the needs identified in the individual treatment plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1713 (September 2015).

§5691. Behavioral Health Service Providers with a Mental Health Program that Provide Services Only in the Home and Community

A. The BHS provider with only a home and community-based mental health program shall notify HSS of the parishes in the state of Louisiana in which it will provide services. The parishes shall be contiguous.

B. Business Office. The provider offering behavioral health services only in the home or community shall have a business location that:

- 1. is part of the licensed location of the BHS provider;
- 2. is located in a parish where the provider offers services;
- 3. has at least one employee on duty in the business office during hours of operation listed on the approved license application;
- 4. stores the administrative files, including governing body documents, contracts to which the provider is a party, insurance policies, budgets and audit reports, personnel files, client records, policies and procedures, and other files or documents the BHS provider is required to maintain; and
- 5. is not located in an occupied personal residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1713 (September 2015).

Subchapter M. Additional Requirements for Substance Abuse/Addiction Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides substance abuse/addiction treatment services must meet the requirements of Subchapter M.

§5693. General Requirements

A. The BHS provider shall provide, either directly or through referral:

1. access to HIV counseling and testing services;
2. access to testing for pregnancy, tuberculosis and sexually transmitted diseases; and
3. appropriate follow-up referral and care.

B. Staffing

1. Medical Director

a. The provider shall ensure that its medical director is a licensed physician who:

- i. is an addictionologist; or
- ii. meets all of the following:
 - (a). is board-eligible or board-certified;
 - (b). has two years of qualifying experience in treating addictive disorders; and
 - (c). maintains a consulting relationship with an addictionologist.

b. A PA may perform duties as designated by the supervising physician in accordance with the Louisiana State Board of Medical Examiners.

c. The APRN shall be in collaborative practice with a physician in accordance with the Louisiana State Board of Nursing.

2. LMHPs. The LMHP providing addiction treatment services shall have documented credentials, experience and/or training in working with clients who have addictive disorders.

3. UPs. A UP providing addiction treatment services shall meet one of the following qualifications:

a. a master's-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in addiction treatment settings, the master's prepared UP shall be supervised by a LMHP who meets the requirements of this Section;

b. be a registered addiction counselor;

c. be a certified addiction counselor; or

d. be a counselor in training (CIT) that is registered with ADRA and is currently participating in a supervisory relationship with a ADRA-registered certified clinical supervisor (CCS).

C. Policies and Procedures. The BHS provider shall have a policy and procedure that addresses drug screen tests and collections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015).

§5695. Addiction Outpatient Treatment Program (ASAM Level I)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level I into this program;

2. provide fewer than nine contact hours per week for adults and fewer than six hours per week for children/adolescents; and

3. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 90 days.

B. Staffing. The provider shall ensure that:

1. there are physician services available as needed for the management of psychiatric and medical needs of the clients;

a. physician services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement;

2. there is a clinical supervisor available on site for supervision as needed, and available on call at all times;

3. there is at least one LMHP or UP on-site when clinical services are being provided;

4. each LMHP/UP's caseload does not exceed 1:50 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015).

§5697. Intensive Outpatient Treatment Programs (ASAM Level II.1)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level II.1 into this program;

2. maintain a minimum of 9 contact hours per week for adults, at a minimum of three days per week, with a maximum of 19 hours per week;

3. maintain a minimum of 6 hours per week for children/adolescents, at a minimum of three days per week, with a maximum of 19 hours per week; and

4. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days.

B. Staffing. The provider shall ensure that:

1. a physician is on site as needed for the management of psychiatric and medical needs and on call 24 hours per day, seven days per week;

2. there is a clinical supervisor on-site 10 hours a week and on call 24 hours per day, seven days per week;

3. there is at least one LMHP or UP on site when clinical services are being provided;

4. each LMHP/UP caseload does not exceed 1:25 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written

contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015).

§5699. Ambulatory Detoxification with Extended On-Site Monitoring (ASAM Level II-D) (Adults Only)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level II-D into this program;
2. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days; and
3. ensure that level II-D services are offered in conjunction with intensive outpatient treatment services (ASAM level II.1);

B. Staffing. The provider shall ensure that:

1. a physician is on-site at least 10 hours per week during operational hours and on-call 24 hours per day, seven days per week;
2. there is a LMHP or UP on site 40 hours per week;
3. each LMHP/UP caseload does not exceed 1:25 active clients;
4. there is a licensed nurse on call 24 hours per day, seven days per week and on site no less than 40 hours a week; and
5. there is a RN on-site as needed to perform nursing assessments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

Chapter 57. Behavioral Health Services

§5701. Clinically Managed Low-Intensity Residential Treatment Program (ASAM Level III.1)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level III.1 into its Clinically Managed Low-Intensity Residential Treatment Program;
2. offer at least five hours per week of a combination of low-intensity clinical and recovery focused services, including:
 - a. individual therapy;
 - b. group and family therapy;
 - c. medication management; and
 - d. medication education;
3. ensure that the treatment plan is reviewed in collaboration with the client at least every 90 days;
4. provide case management that is:
 - a. provided by a care coordinator who is on duty as needed; or
 - b. assumed by the clinical staff.

B. Staffing

1. The provider shall have a clinical supervisor available for clinical supervision and by telephone for consultation.
2. There shall be at least one LMHP or UP on duty at least 40 hours a week.
3. Adult Staffing Patterns

- a. The LMHP/UP caseload shall not exceed 1:25 active clients.

- b. There shall be at least one direct care aide on duty during each shift.

4. Children/Adolescent Staffing Patterns

- a. The UP caseload shall not exceed 1:8 active clients.

- b. The provider shall have at least two direct care aides on duty during each shift.

- c. There shall be a ratio of 1:8 direct care aides during all shifts and a ratio of 1:5 direct care aides on therapy outings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

§5703. Clinically Managed Residential Detoxification (Social Detoxification) (ASAM Level III.2D)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level III.2D into its Clinically Managed Residential Detoxification Program;

2. screen each client upon arrival for at least the following to ensure proper placement:

- a. withdrawal potential;
- b. biomedical conditions; and
- c. cognitive/emotional complications;

3. have at least one staff member on each shift trained in cardiopulmonary resuscitation (CPR);

4. develop and implement an individualized stabilization/treatment plan in collaboration with the client that:

- a. shall be reviewed and signed by the UP and the client; and

- b. shall be filed in the client's record within 24 hours of admission;

5. provide case management that is:

- a. provided by a care coordinator who is on duty as needed; or
- b. assumed by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless assessed and evaluated by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness associated with detoxification and to access emergency services promptly.

C. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP available on site at least 40 hours per week; and

4. for adults:

- a. each LMHP/UP's caseload shall not exceed 1:25;

- b. there is at least one direct care aide per shift with additional as needed;
- 5. for children/adolescents:
 - a. each LMHP/UP's caseload shall not exceed 1:16;
 - b. there are at least two direct care aides per shift with additional as needed; and
 - c. the ratio of aides to clients shall not exceed 1:10.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

§5705. Clinically Managed Medium-Intensity Residential Treatment (ASAM Level III.3) (Adult Only)

A. The provider shall:

- 1. only admit clients clinically appropriate for ASAM level III.3 into its Clinically Managed Medium-Intensity Residential Program;
- 2. offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services;
- 3. ensure that the treatment plan is reviewed in collaboration with the client as needed or at a minimum of every 90 days and documented accordingly; and
- 4. provide case management that is:
 - a. provided by a care coordinator who is on duty as needed; or
 - b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

- 1. there is a physician on call 24 hours per day and on duty as needed for management of psychiatric and medical needs;
- 2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
- 3. there is 24 hour on-call availability by an RN plus a licensed nurse on duty whenever needed to meet the professional nursing requirements;
- 4. there is a LMHP or UP on site 40 hours a week to provide direct client care;
- 5. each LMHP/UP caseload shall not exceed 1:12; and
- 6. there is at least one direct care aide on duty for each shift plus additional aides as needed.

C. Mothers with Dependent Children Program (Dependent Care Program)

- 1. A provider's Mothers with Dependent Children Program shall:
 - a. meet the requirements of ASAM level III.3;
 - b. provide weekly parenting classes where attendance is required;
 - c. address the specialized needs of the parent;
 - d. provide education, counseling, and rehabilitation services for the parent that further addresses:
 - i. the effects of chemical dependency on a woman's health and pregnancy;
 - ii. parenting skills; and
 - iii. health and nutrition;
 - e. regularly assess parent-child interactions and address any identified needs in treatment; and
 - f. provide access to family planning services.

2. Child Supervision

a. The provider shall ensure that it provides child supervision appropriate to the age of each child when the mother is not available to supervise her child.

b. The provider shall ensure that its child supervision is provided by either:

i. the provider's on-site program with all staff members who:

- (a). are at least 18 years old;
- (b). have infant CPR certification; and
- (c). have at least eight hours of training in the following areas prior to supervising children independently:

(i). chemical dependency and its impact on the family;

(ii). child development and age-appropriate activities;

(iii). child health and safety;

(iv). universal precautions;

(v). appropriate child supervision techniques; and

(vi). signs of child abuse; or

ii. a licensed day care provider pursuant to a written agreement with the provider.

c. The provider shall maintain a staff-to-child ratio that does not exceed 1:3 for infants (18 months and younger) and 1:6 for toddlers and children.

d. Child Specialist. The provider shall have a child specialist who:

i. is available to provide staff training, evaluate effectiveness of direct care staff, and plan activities, for at least one hour per week per child;

ii. has 90 clock hours of education and training in child development and/or early childhood education; and

iii. has one year of documented experience providing services to children.

e. Clients shall not supervise another parent's child or children without written consent from the legal guardian and staff approval.

f. Staff shall check all diapers frequently and change as needed, dispose of the diapers in a sealed container and sanitize the changing area.

3. Clinical Care for Children. The provider shall:

a. address the specialized and therapeutic needs and care for the dependent children and develop an individualized plan of care to address those needs, to include goals, objectives and target dates;

b. provide age-appropriate education, counseling, and rehabilitation services for children that address or include:

i. the emotional and social effects of living with a chemically dependent care-giver;

ii. early screening and intervention of high risk behavior and when indicated provide or make appropriate referrals for services;

iii. screening for developmental delays; and

iv. health and nutrition;

c. ensure that all children have access to medical care when needed;

d. ensure that children are administered medication according to the label by the parent or licensed staff qualified to administer medications; and

e. ensure that if licensed staff will be administering medications, the provider:

i. obtains written consent from the parent to administer the prescribed and over the counter medications, including identifying information relative to dosage, route, etc.;

ii. assumes full responsibility for the proper administration and documentation of the medications; and

iii. ensures original labeled medication containers with name, dosage, route, etc. are obtained prior to medication administration.

f. maintain current immunization records and allergy records for each child at the program site; and

g. obtain consent for emergency medical care for each child at admission.

4. Child Services

a. The daily activity schedule for the children shall include a variety of structured and unstructured age-appropriate activities.

b. School age children shall have access to school.

c. The health, safety, and welfare of the children shall be protected at all times.

d. Behavior management shall be fair, reasonable, consistent, and related to the child's behavior. Physical discipline is prohibited.

e. The children shall be well-groomed and dressed weather-appropriate.

f. An adequate diet for childhood growth and development, including two snacks per day, shall be provided to each child.

5. The program shall develop, implement and comply with written policies and procedures that:

a. address abuse and/or neglect of a child;

b. prohibit children under the age of 18 months from sleeping in bed with their mothers;

c. require a current schedule showing who is responsible for the children at all times;

d. address isolating parents and children who have communicable diseases and providing them with appropriate care and supervision; and

e. identify those persons authorized to remove a child from the facility other than legal guardian or parent.

6. Safety and Emergency Preparedness

a. The program shall develop and implement an emergency preparedness plan that includes provisions and services for the clients and children.

b. The program shall ensure that all toys and equipment are age appropriate, in good order and safe condition, and in accordance with manufacturer's recommendations.

c. Staff, volunteers, and parents shall use universal precautions at all times.

d. The provider shall ensure that only the legal guardian or a person authorized by the legal guardian may remove a child from the provider.

e. If an individual shows documentation of legal custody, staff shall record the person's identification before releasing the child.

7. Physical Environment

a. The program shall provide potty chairs for small children and sanitize them after each use.

b. The program shall provide age-appropriate bathing facilities. Infants shall not be bathed in sinks.

c. Each child shall be provided with his/her own bed.

d. Infants up to 18 months shall sleep in either a bassinet or cribs appropriate to the size of the child.

e. The provider shall provide a variety of age-appropriate equipment, toys, and learning materials for the children/adolescents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1716 (September 2015).

§5707. Clinically Managed High-Intensity Residential (ASAM Level III.5)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.5 into its Clinically Managed High Intensity Residential Treatment Program;

2. the treatment plan is reviewed in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. the provider shall have one licensed RN on call 24/7 to perform nursing duties for the provider; and

4. there shall be at least one LMHP or UP on duty at least 40 hours per week;

5. for adult staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:12;

b. there shall be at least one direct care aide on duty on all shifts with additional as needed; and

c. there shall be at least one licensed nurse on duty during the day and evening shifts to meet the nursing needs of the clients. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement;

6. for children/adolescent staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:8; and

b. there shall be at least two direct care aides on duty during all shifts with additional as needed. The ratio of aides to clients shall not exceed 1:8. On therapy outings, the ratio shall be at least 1:5;

c. there shall be a psychologist available when needed; and

d. there shall be a licensed nurse on duty to meet the nursing needs of the clients.

i. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1717 (September 2015).

§5709. Medically Monitored Intensive Residential (ASAM Level III.7) (Adults only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7 into its Medically Monitored Intensive Residential Treatment Program; and

2. the treatment plan is reviewed and updated in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP on duty at least 40 hours/week;

4. there is at least one RN on call 24 hours per day, seven days per week to perform nursing duties and at least one licensed nurse is on duty during all shifts with additional licensed nursing staff to meet the nursing needs of the clients;

5. its on-site nursing staff is solely responsible for III.7 program and does not provide services for other levels of care at the same time;

6. each LMHP/UP caseload shall not exceed 1:10;

7. there is at least one direct care aide on duty on all shifts with additional as needed;

8. there is an activity or recreational therapist on duty at least 15 hours per week.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1718 (September 2015).

§5711. Medically Managed Residential Detoxification (Medical Detoxification) (ASAM Level III.7D) (Adults Only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7D into its Medically Managed Residential Detoxification Program;

2. ensure that:

a. a physical examination is conducted by a physician, PA or APRN within 24 hours of admission; or

b. the provider's admitting physician reviews and approves a physical examination conducted by a physician, PA or APRN within 24 hours prior to admission;

3. ensure that each client's progress is assessed at least daily;

4. ensure that each client's physical condition, including vital signs, is assessed at least daily, or more frequently as indicated by physician's order or change in the client's status;

5. have a reliable, adequately sized emergency power system to provide power during an interruption of normal electrical service;

6. provide case management that is conducted:

a. by a care coordinator who is on duty as needed; or

b. by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless seen by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

C. Staffing

1. The provider shall have a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients.

2. Nursing

a. The provider shall have at least one RN on call 24 hours per day, seven days per week to perform nursing duties.

b. There shall be at least one licensed nurse on duty during all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

c. There shall be a RN on-site no less than 40 hours per week who is responsible for conducting nursing assessments upon admission and delegating staffing assignments to the nursing staff based on the assessments and the acuity levels of the clients.

d. The provider shall ensure that its on-site nursing staff is solely responsible for III.7D program and does not provide services for other levels of care at the same time.

e. The nursing staff is responsible for:

i. monitoring client's progress; and

ii. administering medications in accordance with physician orders.

3. Clinical Supervisor and Unlicensed Professionals

a. The provider shall have a clinical supervisor available for clinical supervision when needed and by telephone for consultation.

b. The LMHP/UP caseload shall not exceed 1:10.

4. There shall be at least one direct care aide on all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

5. The provider shall have at least one employee on duty certified in CPR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1718 (September 2015).

Subchapter N. Additional Requirement for Substance Abuse/Addictive Residential Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, residential programs that treat substance abuse/addiction must meet the applicable requirements below.

§5713. Client Funds and Assets

A. If a BHS provider manages clients' personal funds accounts, the BHS provider shall develop and implement written policies and procedures governing the maintenance and protection of the client fund accounts that include, but are not limited to:

1. the maximum amount each client may entrust with the provider;
2. the criteria by which clients can access money;
3. the disbursement procedure, including the maximum amount that may be disbursed to the client;
4. staff members who may access such funds; and
5. the method for protecting and maintaining the funds.

B. The BHS provider that manages a client's personal funds shall:

1. furnish a copy of the provider's policy and procedures governing the maintenance and protection of client funds to the client or the client's parents or legal guardian, if applicable;
2. obtain written authorization from the client or the client's parent or legal guardian, if applicable, for the safekeeping and management of the funds;
3. provide each client with an account statement upon request with a receipt listing the amount of money the provider is holding in trust for the client;
4. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;
5. provide a list or account statement regarding personal funds upon request of the client; and
6. be prohibited from commingling the clients' funds with the provider's operating account.

C. If the BHS provider manages funds for a client, the provider shall ensure that:

1. any remaining funds shall be refunded to the client or his/her legal guardian within five business days of notification of discharge; and
2. in the event of the death of a client, any remaining funds are refunded to the client's legal representative within five business days of the client's death.

D. The BHS provider shall develop, implement and comply with a policies and procedures that address:

1. the maintenance and safeguard of client possessions, including money, brought to the provider by its clients;
2. maintaining an inventory of each client's possessions from the date of admission;
3. returning all possessions to the client upon the client's discharge; and
4. requiring the client and one staff member to sign documentation indicating that the client's possessions have been placed with the provider and the return of possessions to the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015).

§5715. Dietary Services

A. The residential BHS provider shall ensure that:

1. all dietary services are provided under the direction of a Louisiana licensed dietician;
2. menus are approved by a licensed dietician;
3. meals are of sufficient quantity and quality to meet the nutritional needs of clients, including religious and dietary restrictions;
4. meals are in accordance with FDA dietary guidelines and the orders of the authorized licensed prescriber;
5. at least three meals plus an evening snack are provided daily with no more than 14 hours between any two meals;
6. all food is stored, prepared, distributed, and served under safe and sanitary conditions in accordance with the Louisiana state *Sanitary Code*;
7. all equipment and utensils used in the preparation and serving of food are properly cleaned, sanitized and stored in accordance with the Louisiana state *Sanitary Code*; and
8. if meals are prepared on-site, they are prepared in an OPH approved kitchen.

B. The BHS provider may provide meal service and preparation pursuant to a written agreement with an outside food management company. If provided pursuant to a written agreement, the provider shall:

1. maintain responsibility for ensuring compliance with this Chapter;
2. ensure that the outside food management company possesses a valid OPH retail food permit; and
3. ensure that, if the provider does not employ or directly contract with a licensed dietician, the food management company employs or contracts with a licensed dietician who serves the provider as needed to ensure that the nutritional needs of the clients are met in accordance with the authorized licensed prescriber's orders and acceptable standards of practice.

C. The licensed dietician shall:

1. approve therapeutic menus; and
2. be available for consultation when necessary.

D. If the BHS provider has a program that allows menu planning and preparation by clients, the provider shall develop and implement a policy with guidelines for the participating clients that:

1. ensures that meal preparation/service, with client participation, meets all requirements listed above; and
2. defines client's participation in writing and has written instructions posted or easily accessible to clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015).

§5717. Transportation

A. A residential BHS provider shall assist in arranging for or provide transportation necessary for implementing the client's treatment plan, including but not limited to, court-ordered hearings and medically necessary appointments with a health care provider.

B. The BHS provider may provide transportation pursuant to a written agreement with an outside transportation service. If provided pursuant to a written agreement, the provider shall maintain responsibility for ensuring compliance with this Chapter.

C. Any vehicle used to transport a BHS provider's client shall be:

1. properly licensed and inspected in accordance with state law;
2. maintained in a safe condition;
3. operated at a climate controlled temperature that does not compromise the health, safety or needs of the client; and
4. operated in conformity with all of the applicable motor vehicle laws, including but not limited to, utilization of seat belts and vehicular child restraint systems.

D. The provider shall ensure that it or its contracted transportation service:

1. has documentation of current liability insurance coverage for all owned and non-owned vehicles used to transport clients. The personal liability insurance of a provider's employee shall not be substituted for the required coverage;
2. utilizes only drivers who are properly licensed and insured to operate that class of vehicle in accordance with state laws, rules and regulations;
3. obtains a driving history record from the state Office of Motor Vehicles for each employee upon hire and annually thereafter;
4. prohibits the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle; and
5. determines the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff responsible for transporting clients.

E. The provider shall comply with the following when transporting disabled non-ambulatory clients in a wheelchair:

1. a ramp to permit entry and exit of a client from the vehicle;
2. wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners; and
3. the client is securely fastened in the wheelchair.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015).

§5719. Staffing

A. The provider shall ensure that there are at least two staff persons on site at all times when a client is present.

B. House Manager

1. A residential provider shall have a house manager.
2. The house manager shall:
 - a. be at least 21 years old;
 - b. have at least two years qualifying experience working for a provider that treats clients with mental illness and/or addiction disorders;
 - c. supervise the activities of the facility when the professional staff is not on duty;

- d. perform clinical duties only if licensed to do so;
- e. report incidents of abuse, neglect and misappropriation to the medical director;
- f. identify and respond to and report any crisis situation to the clinical supervisor when it occurs; and
- g. coordinate and consult with the clinical staff as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 41:1720 (September 2015).

§5721. Policies and Procedures

A. House Rules and Regulations. A residential provider shall:

1. have a clearly written list of house rules and regulations governing client conduct and behavior management;
2. provide a copy of the house rules and regulations to all clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission;
3. post the rules and regulations in an easily accessible location in the provider and make them available when requested; and
4. have a policy and procedure that pertains to the bedroom assignment of its clients, with consideration given to age, client's diagnosis and severity of client's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1720 (September 2015).

Subchapter O. Additional Requirements for Opioid Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, opioid treatment programs must also meet the requirements of Subchapter O.

§5723. General Provisions

A. A provider with an opioid treatment program shall:

1. meet the requirements of the protocols established by OBH/state opioid authority;
2. update the Louisiana methadone central registry daily and as needed;
3. upon the death of a client:
 - a. report the death of a client enrolled in their clinic to the SOA within 24 hours of the discovery of the client's death;
 - b. report the death of a client to HSS within 24 hours of discovery if the death is related to program activity;
 - c. submit documentation on the cause and/or circumstances to SOA and to HSS, if applicable, within 24 hours of the provider's receipt of the documentation; and
 - d. adhere to all protocols established by DHH on the death of a patient; and
4. conduct at least eight random monthly drug screen tests on each client per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1720 (September 2015).

§5725. Treatment

A. Client Admission Criteria. The program shall only admit clients that:

1. are at least 18 years old, unless the client has consent from a parent, or legal guardian, if applicable;
2. meet the federal requirements regarding the determination that the client is currently addicted to opiates and has been addicted to opiates for at least one year prior to admission or the exceptions;
3. are verified by a physician that treatment is medically necessary;
4. have had a complete physical evaluation by the client's or program's physician before admission to the opioid treatment program;
5. have had a full medical exam, including results of serology and other tests, completed within 14 days of admission; and
6. have a documented history of opiate addiction.

B. Treatment Phases

1. Initial Treatment. During the initial treatment phase that lasts from three to seven days in duration, the provider shall:

- a. conduct client orientation;
- b. provide individual counseling; and
- c. develop the initial treatment plan including initial dose of medication and plan for treatment of critical health or social issues.

2. Early Stabilization. In the early stabilization period that begins on the third to seventh day following initial treatment through 90 days duration, the provider shall:

- a. conduct weekly monitoring by a nurse of the client's response to medication;
- b. provide at least four individual counseling sessions;
- c. revise the treatment plan within 30 days to include input by all disciplines, the client and significant others; and
- d. conduct random monthly drug screen tests.

3. Maintenance Treatment. In the maintenance treatment phase that follows the end of early stabilization and lasts for an indefinite period of time, the provider shall provide:

- a. random monthly drug screen tests until the client has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated;
- b. thereafter, monthly testing to clients who are allowed six days of take-home doses, as well as random testing for alcohol when indicated;
- c. continuous evaluation by the nurse of the client's use of medication and treatment from the program and from other sources;
- d. documented reviews of the treatment plan every 90 days in the first 2 years of treatment by the treatment team; and
- e. documentation of response to treatment in a progress note at least every 30 days.

4. Medically Supervised Withdrawal from Synthetic Narcotic with Continuing Care. Medically supervised withdrawal is provided if and when appropriate. If provided, the provider shall:

a. decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by the client;

b. provide counseling of the type and quantity determined by the indicators and the reason for the medically supervised withdrawal from the synthetic narcotic; and

c. conduct discharge planning with continuity of care to assist client to function without support of the medication and treatment activities.

5. Required Withdrawal. The provider shall provide medically-approved and medically-supervised assistance to withdrawal from the synthetic narcotic when:

- a. the client requests withdrawal;
- b. quality indicators predict successful withdrawal;

or

- c. client or payer source suspends payment of fees.

C. Counseling. The provider shall ensure that:

1. counseling is provided when requested by the client or client's family;

2. written criteria are used to determine when a client will receive additional counseling;

3. the type and quantity of counseling is based on the assessment and recommendations of the treatment team;

4. written documentation supports the decisions of the treatment team, including indicators such as positive drug screens, maladjustment to new situations, inappropriate behavior, criminal activity, and detoxification procedure; and

5. all counseling is provided individually or in homogenous groups, not to exceed 12 clients.

D. Physical Evaluations/Examinations. The provider shall ensure that each client has a documented physical evaluation and examination by a physician or advanced practice registered nurse as follows:

1. upon admission;
2. every other week until the client becomes physically stable;
3. as warranted by client's response to medication during the initial stabilization period or any other subsequent stabilization period;
4. after the first year and annually thereafter; and
5. any time that the client is medically unstable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1721 (September 2015).

§5727. Additional Staffing Requirements

A. The provider's opioid treatment program shall have the following staff in addition to the general staffing requirements.

1. Pharmacist or Dispensing Physician

a. An opioid treatment program that dispenses prescription medication on-site shall employ or contract with a pharmacist or dispensing physician to assure that any prescription medication dispensed on-site meets the requirements of applicable state statutes and regulations.

b. The pharmacist or dispensing physician shall have a current, valid unrestricted license to practice in the state of Louisiana.

c. The provider's pharmacist or dispensing physician shall:

- i. provide on-site services;
- ii. dispense all medications;
- iii. consult with the provider as needed;
- iv. evaluate medication policy and procedure of provider to dispense medications;
- v. reconcile inventories of medications that were dispensed and/or administered at least every 30 days;
- vi. maintain medication records for at least three years in accordance with state laws, rules and regulations; and
- vii. approve all transport devices for take-home medications in accordance with the program's diversion control policy.

2. Nursing

- a. The provider shall maintain a nursing staff sufficient to meet the needs of the clients.
- b. Each nurse shall have a current unrestricted license to practice nursing in the state of Louisiana.
- c. The responsibilities of the nurse(s) include but are not limited to:
 - i. administering medications; and
 - ii. monitoring the client's response to medications.

3. Licensed Mental Health Professionals

- a. The provider shall maintain a sufficient number of LMHPs to meet the needs of its clients and there is at least one LMHP or UP on site when clinical services are being provided.
- b. The provider shall ensure that:
 - i. the caseload of the LMHP shall not exceed 75 active clients; and
 - ii. there is an LMHP on site at least five hours/week.

4. Unlicensed Professionals

- a. The provider shall have UPs sufficient to meet the needs of the clients.
- b. The caseload of the UP shall not exceed 75 active clients.

5. Physician or APRN. There shall be a physician or APRN who is on-site as needed or on-call as needed during hours of operation.

B. Training. All direct care employees shall receive orientation and training for and demonstrate knowledge of the following, including, but not limited to:

1. symptoms of opiate withdrawal;
2. drug screen testing and collections;
3. current standards of practice regarding opiate addiction treatment;
4. poly-drug addiction; and
5. information necessary to ensure care is provided within accepted standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1721 (September 2015).

§5729. Medications

A. The provider shall ensure that all medications are administered by a nurse, pharmacist or other practitioner licensed under state law and authorized by federal and state law to administer or dispense opioid drugs.

B. Take-Home Dose(s)

1. The provider shall ensure that:

- a. determinations for take-home dose(s) and the factors considered are made by the client's treatment team and are documented in the client's record when each take-home dose is authorized;
- b. date and recommended dosage are documented in the client's record; and
- c. take-home dose(s) are ordered by the medical director.

2. The provider shall ensure that the following factors are considered by the medical director and treatment team before a take-home dose is authorized by the treatment team:

- a. a negative drug/alcohol screen for at least 30 days;
- b. documented regularity of clinic attendance relative to treatment plan;
- c. absence of serious behavioral problems;
- d. absence of known criminal activity;
- e. absence of known drug related criminal activity during treatment;
- f. stability of home environment and social relationships;
- g. assurance that take-home medication can be safely stored; and
- h. whether the benefit to the client outweighs the risk of diversion.

3. Standard Schedule. The provider shall abide by the following schedule of take-home, therapeutic doses when a take-home dose is authorized:

- a. after the first 30 days of treatment, and during the remainder of the first 90 days of treatment, one take-home, therapeutic dose per week;
- b. in the second 90 days of treatment, two doses, consisting of take-home, therapeutic doses, may be allowed per week;
- c. in the third 90 days of treatment, three doses consisting of take-home, therapeutic doses may be allowed per week;
- d. in the final 90 days of treatment during the first year, four doses consisting of take-home, therapeutic doses may be allowed per week;
- e. after one year in treatment, a six-day dose supply consisting of take-home, therapeutic doses may be allowed once a week;
- f. after two years in treatment, a 13-day dose supply consisting of take-home, therapeutic doses may be allowed once every two weeks.

4. Loss of Privilege. Positive drug screens at any time for any drug other than those prescribed shall require a new determination to be made by the treatment team regarding take-home doses.

5. Exceptions to the Standard Schedule. The provider must request and obtain approval for an exception to the standard schedule from the state opioid authority. Any exception must be for an emergency or severe travel hardship.

B. Temporary Transfers or Guest Dosing. The providers involved in a temporary transfer or guest dosing shall ensure the following:

1. the receiving provider shall verify dosage prior to dispensing and administering medication;
2. the sending provider shall verify dosage and obtain approval and acceptance from receiving provider prior to client's transfer; and
3. that documentation to support all temporary transfers and guest dosing is maintained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1722 (September 2015).

§5731. Client Records

A. In addition to the general requirements for client records, each client record shall contain:

1. recording of medication administration and dispensing in accordance with federal and state requirements;
2. results of five most recent drug screen tests with action taken for positive results;
3. physical status and use of additional prescription medication;
4. monthly or more frequently, as indicated by needs of client, contact notes and progress notes which include employment/vocational needs, legal and social status, and overall individual stability;
5. documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;
6. documentation of approval of any exception to the standard schedule of take-home doses and the physician's justification for such exception; and
7. any other pertinent information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015).

Kathy H. Kliebert
Secretary

1509#088

RULE

Department of Health and Hospitals Bureau of Health Services Financing

Targeted Case Management
Foster Care and Family Support Worker Services
(LAC 50:XV.Chapter 115)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:XV.Chapter 115 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act.

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

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 7. Targeted Case Management

Chapter 115. Foster Care and Family Support Worker Services

§11501. Introduction

A. Effective for dates of service on or after July 1, 2015, the department shall reimburse the Department of Children and Family Services (DCFS) for case management and case management supervision services, provided by DCFS foster care and family support workers, which qualify for Medicaid reimbursement under the Targeted Case Management Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015).

§11503. Covered Services

A. The Medicaid Program shall provide reimbursement to DCFS for the following case management services:

1. comprehensive assessment of individual needs;
2. periodic reassessment of individual needs;
3. development and periodic revision of a specific care plan;
4. referral and related activities; and
5. monitoring and follow-up activities.

B. Covered services and activities may be rendered to the child, the foster family, or biological family.

C. Case management functions provided by DCFS family support workers include, but are not limited to:

1. completing a safety and risk assessment of the child;
2. completing assessment of family functioning—initial and on-going to include trauma screening as well as screenings for mental health, domestic violence and substance abuse issues;
3. developing a written care plan, jointly with the family, within the first 30 days;
4. providing on-going service planning;
5. providing on-going monitoring of the care plan through home visits, phone calls, etc.; and
6. providing a link to community resources for parents and children including:

- a. referrals to substance abuse;
- b. mental health services;
- c. domestic violence;
- d. daycare services;
- e. the EarlySteps program;
- f. medical services;
- g. family resource center services;
- h. parenting services;
- i. visit coaching; and
- j. skills building.

D. Case management functions provided by DCFS foster care workers include, but are not limited to:

1. completing a social history and assessment;
2. arranging an initial medical, dental and communicable disease screening upon entry into foster care;

3. obtaining the medical history of child upon entering foster care, as well as immunization records;
4. completing a behavioral health screening within 15 days of child entering foster care;
5. exploring all federal benefits for the child (SSI, death benefits, etc.);
6. developing case plans and objectives with the family;
7. preparing cases for presentation to the multi-disciplinary team for consultation;
8. coordinating with other professionals regarding the needs of the child, family, and/or parent;
9. continuously assessing the safety of the child and service needs of the child(ren) and families through interviews, observations and other information sources; and
10. providing supportive services for clients and arranges for the provision of services from community resources based on the case plan.

E. The following DCFS services shall not be covered:

1. research gathering and completion of documentation for foster care program;
2. assessing adoption placement;
3. recruiting/interviewing foster parents;
4. serving legal papers;
5. home investigations;
6. transportation;
7. administering foster care subsidies; and
8. making placement arrangements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015).

§11505. Reimbursement

A. The department shall utilize a random moment sampling (RMS) procedure as the cost allocation process to determine the reimbursement for services rendered by DCFS staff.

B. RMS will statistically validate the method for determining the percentage of effort expended by DCFS foster care and family support workers for case management services rendered to Medicaid eligible children.

C. DCFS foster care and family support workers who render case management services will be randomly selected at a date, time, and frequency designated by the department to participate in a survey, or other process, to determine the amount of time and efforts expended on the targeted population for Medicaid covered services. The RMS responses will be compiled and tabulated using a methodology determined by the department. The results will be used to determine the cost associated with administering the Medicaid covered TCM services, and the final reimbursement to DCFS for the services rendered.

D. As part of its oversight responsibilities, the department reserves the right to develop and implement any audit and reviewing procedures that it deems are necessary to ensure that payments to DCFS for case management services are accurate and are reimbursement for only Medicaid allowable costs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1724 (September 2015).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1509#087

RULE

Department of Natural Resources Office of Mineral Resources

Reorganization of Office of Mineral Resources Regulations (LAC 43:V.Chapters 5-9)

The Department of Natural Resources, Office of Mineral Resources has moved LAC 43:I.Chapters 9-11 to LAC 43.V.Chapters 5-9. This reorganization is done to properly place rules regarding mineral resources in Part V, Office of Mineral Resources.

This placement has been done in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. No changes have been made to any of those rules formerly located in LAC 43:I.Chapters 9-11.

Title 43

NATURAL RESOURCES

Part V. Office of Mineral Resources

Chapter 5. Mineral Resources

Editor's Note: Pursuant to Act 196 of the 2009 Regular Session, the name of the State Mineral Board has been changed to State Mineral and Energy Board.

Subchapter A. Mineral Leasing Policy

§501. Nomination

[Formerly LAC 43:I.901]

A. All parties desiring to nominate state owned land and waterbottom acreage or land owned by a state agency for which the State Mineral Board is being requested to issue a mineral lease must be registered with the Office of Mineral Resources on a one-time basis and have received an applicant ID number prior to submitting application for nomination.

B. The State Mineral Board has the authority to lease state owned lands and waterbottoms (see R.S. 30:124) and state agency owned land when requested to do so (see R.S. 30:153).

C. Application for nomination generally must include a diskette or CD-ROM containing a .dxf format of the proposed nominated tract polygon and a word.doc legal description of the same proposed nominated tract which must exactly match the tract polygon exploded from the .dxf as to X,Y coordinates along the polygon outline based on the Lambert Coordinate System; a paper copy of the plat and the legal description which each must match the .dxf exploded polygon and the word.doc; an electronic .pdf file of the plat; a letter of application completely and accurately filled out

and a non-refundable check in the amount of the nomination fee as set forth in R.S. 9:301(2) (presently \$400). More detailed requirements and certain exceptions are contained in the Leasing Manual available on the Department of Natural Resources (DNR) website at <http://dnr.louisiana.gov/min/petlan/leasing.asp>.

D. Nominated acreage for one nomination cannot exceed 2,500 acres of state owned lands and waterbottoms, in the aggregate, nor can the polygon outline of the nominated tract exceed 3 1/2 miles on a side, generally speaking, and must be given, where possible, in Lambert (X,Y) Coordinates at critical points along the boundary of the nomination polygon together with meets and bounds. Certain exceptions to this rule may be found in the leasing manual available on the DNR website as hereinabove set forth.

E. Advertising of nominations cannot occur more than 60 days prior to the date on which sealed bids are to be opened and must be done in the official state journal and the official parish journal wherein the nomination lies. The advertisement must contain a description of the land nominated, the time and place where the sealed bids shall be received and opened (which must be a state owned building in the state capital), a statement that the bid may be for the whole or any particularly described portion of the advertised land and may contain any other information deemed necessary by the mineral board [R.S. 30:126(A)]. The Office of Mineral Resources also publishes a notice book each month of tracts available for bidding at the next month's mineral lease sale which is available to the public for a yearly subscription price of \$120. A copy of the notice book is available for viewing on the DNR website.

F. A nomination may be withdrawn at the request of the applicant prior to its being advertised for lease; thereafter, the request for withdrawal must be reviewed by the State Mineral Board and approved for withdrawal at the regularly scheduled monthly State Mineral Board meeting.

G. For more detailed information on nominations abutting or enclosing existing, active state mineral leases, abutting the 3 mile boundary between state and federal waters, abutting neighboring states, nominations of particular tract kinds—such as wildlife management areas under the jurisdiction of the Department of Wildlife and Fisheries, Sixteenth Section lands, vacant state lands, school indemnity lands, state agency lands, tax adjudicated lands and other specialized types of acreage requiring type specific handling, see the leasing manual available on the DNR website as set forth hereinabove.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:354(A).

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:254 (February 2008), repromulgated LR 41:1724 (September 2015).

§502. Bidding

[Formerly LAC 43:I.902]

A. Bids for state mineral leases shall only be accepted from those parties who are registered prospective leaseholders (having a registration form containing current information regarding the bidder and a current certificate of good standing from the Secretary of State's office indicating prospective bidder is authorized to do business in the state of Louisiana) with the Office of Mineral Resources. Prospective leaseholders must maintain current their registration by notifying the Office of Mineral Resources of

any change of information provided on the registration form and prior to January 31 of each year, if applicable, furnishing the Office of Mineral Resources with a copy of a certificate from the Secretary of State's Office indicating the party is in good standing and remains authorized to do business in the state of Louisiana.

B. Bids for state mineral leases shall be accepted at the place named in the advertisement no later than 12 noon on the Tuesday immediately preceding the Wednesday State Mineral Board meeting (unless specially noticed due to holidays).

C. Bids must be in a sealed envelope with the tract number for which the bid is being submitted legibly typed or written on the outside of the envelope. The bid packet shall contain the official state of Louisiana bid form as secured from the website form file, completely and accurately filled out and signed by an authorized agent of the bidder, a cashier's or certified check, or money order made out to the Office of Mineral Resources for the total amount of the cash bonus being bid (which must match exactly the cash bonus written in on the bid form submitted), a check made out to the Office of Mineral Resources for the sum equaling 10 percent of the total cash bonus bid, a check made out to the Office of Mineral Resources for a sum equaling \$20 multiplied times the total number of acres being bid on (if bid is on entire tract, then multiply \$20 times total tract acreage), a "hard" paper copy of the plat and legal description of a portion bid and a diskette or CD-ROM containing a .dxf file and a word.doc file describing the portion bid (which must match each other and the "hard" copies) and an electronic .pdf file of the plat. Failure to sign the bid form, or a discrepancy between the amount of the cash bonus set forth on the check presented and, if less than, the amount written in on the accompanying bid form, shall invalidate the bid, rendering it unacceptable to the State Mineral Board. Bids once submitted shall not be returned prior to the State Mineral Board meeting for which they were submitted, and then only by permission of the State Mineral Board or if the bid is rejected.

D. Bids shall be opened on the date, and at the time and place specified in the advertisement. If a nominated tract is withdrawn from a particular mineral lease sale by the State Mineral Board for any reason, any bids received on the withdrawn tract shall be returned unopened at the end of the State Mineral Board meeting from which the tract was withdrawn.

E. All bids opened shall be evaluated by the staff of the State Mineral Board and recommendations made as to whether each bid should, or should not, be accepted. The State Mineral Board may then award leases on those bids it deems acceptable—usually at the meeting when the corresponding bids are opened. All bids not accepted shall be returned to the unsuccessful bidder at the end of the meeting at which the bids were opened.

F. Awarded leases are prepared by the staff of the Office of Mineral Resources and sent to the new lessee for signature and recordation in the parish records of the parish(s) in which the lease acreage is located. A fully signed and executed copy of the lease, with recording information, shall then be returned to the Office of Mineral Resources within 20 days of receipt therefrom (failure to so return may

result in forfeiture of lease) and shall be filed in the lease records of that office.

G. More particular information with regards to the bidding procedure may be obtained from the Leasing Manual located on the DNR website as set forth hereinabove.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:354(A).

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:255 (February 2008), repromulgated LR 41:1725 (September 2015).

§503. Assignments and Other Transfers of Interest **[Formerly LAC 43:I.903]**

A. Any assignment or other transfer of an interest in a state mineral lease must be approved by the State Mineral Board and failure to so obtain approval shall render the assignment or transfer null and void (R.S. 30:128).

B. Before any assignment or other transfer of an interest in a state mineral lease is approved, any and all of the assignees must be currently registered prospective leaseholders with the Office of Mineral Resources.

C. Any assignment must clearly show that a working interest in a state mineral lease is being transferred (no net revenue interest, override royalty, well bore interest, or other similar non-working interest transfer will be approved by the State Mineral Board), contain a clear description of the working interest (including legal description of lease portion if applicable) being transferred, not show a greater interest being transferred than is owned by the assignor and be accompanied by a Form B (see the DNR website for file) which shows the decimal working interest of all parties before and after the transfer. The assignment or other transfer must be signed by all assignors requisite to the transfer of the interest being assigned, witnessed and duly notarized (by witness attestation if necessary) in a form legally acceptable in the venue in which the assignment or other transfer is completed.

D. Each assignment or other transfer (more than one lease interest may be assigned or transferred in one assignment document) shall be accompanied by a check for the non-refundable fee as set in the fee schedule of the Office of Mineral Resources (LAC 43, Part V, §301); presently set at \$100.

E. The assignment or other transfer, once approved by the State Mineral Board, shall be filed in the lease records of the Office of Mineral Resources in the file record of the applicable lease(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:354(A).

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:255 (February 2008), repromulgated LR 41:1726 (September 2015).

§504. Laws and Instructions **[Formerly LAC 43:I.904]**

A. The general statutory provisions applicable to mineral leases from the state of Louisiana on state owned lands and waterbottoms are located in R.S. 30:121-221. The general, applicable provisions of the Constitution of the State of Louisiana of 1974, as amended, are Article IX, §§1-5.

B. Instructions regarding obtaining and transferring interests in state mineral leases may be found in the leasing manual located on the Department

of Natural Resources (DNR) website at <http://dnr.louisiana.gov/min/petlan/leasing.asp>.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:354(A).

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:256 (February 2008), repromulgated LR 41:1726 (September 2015).

§505. Mineral Board Policy **[Formerly LAC 43:I.905]**

A. Mineral Board Policy regarding matters of mineral leasing and transfers of mineral lease interests may be obtained on request by telephoning the Office of Mineral Resources at (225) 342-4606.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:354(A).

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:256 (February 2008), repromulgated LR 41:1726 (September 2015).

Subchapter B. Application for Approval of Transfer of Solid Mineral Lease or Sublease

The rules contained herein shall govern every application for approval by the State Mineral Board of a proposed transfer of any lease or sublease entered into by or under the authority of or subject to the jurisdiction of the State Mineral Board which includes the development and production of solid minerals, under the circumstances described in Act 296 of 1979.

§513. Definitions

[Formerly LAC 43:I.913]

A. As used in these regulations, the following terms have the meanings assigned below, unless the context otherwise requires.

Applicant—the person seeking approval by the board of a proposed transfer (as described in Act 296 of 1979) of a lease.

Board—the State Mineral Board of the state of Louisiana.

Control—the term control (including the terms controlling, controlled by and under common control with) means possession (direct or indirect) of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

Director—any director of a corporation or any person performing similar functions with respect to any organization whether incorporated or unincorporated.

Lease—any lease or sublease entered into by or under the authority of or subject to the jurisdiction of the board which includes the development and production of solid minerals.

Lessee—a person or entity which at the time of a proposed transfer (as described in Act 296 of 1979) has the right to develop and produce solid minerals under a lease.

Officer—the chairman, the president, each vice-president in charge of a principal business function, the secretary, the treasurer, and the comptroller, and any other person performing similar functions with respect to any organizations whether incorporated or unincorporated.

Person—a natural person, partnership, syndicate, corporation or any other group or entity.

Secretary—the Secretary of the Department of Natural Resources.

B. Other terms used in these regulations have the same meanings as are set forth in Act 296 of 1979 unless the context otherwise requires.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:131 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1726 (September 2015).

§515. Procedure for Preparing and Filing Applications [Formerly LAC 43:I.915]

A. Date of Filing. At least 20 days (Saturdays, Sundays, and holidays excluded) prior to the date on which the transfer is to be effected, or in the case of a transfer by means of purchase of 10 percent or more of equity securities of the lessee, 20 days prior to such purchase, an application shall be filed with the secretary and delivered by hand to the lessee.

B. Number of Copies and Accompanying Material

1. Two signed copies of the application (including exhibits and all other accompanying papers and documents) shall be filed with the secretary at the Department of Natural Resources, Baton Rouge, LA 70804. One signed copy of such application shall be delivered to the lessee.

2. Each application shall be accompanied by a signed consent of the applicant to the appointment of the secretary as his or its agent for service of any and all pleadings, discovery requests, orders and investigations relating to the application, and, if the applicant is a corporation, by a consent signed by each director and each officer of the applicant (and by each director and each officer of any corporation controlling the applicant) and by any other person identified under §517.A.4.a.ii hereof, agreeing to make himself available for prehearing investigatory or discovery proceedings either in the state of Louisiana or in the state in which the lessee maintains its or his principal executive offices.

3. Each application shall be accompanied by a certified or bank cashier's check in the amount of \$100, payable to secretary, Department of Natural Resources, as an examination fee and, except as provided in §923, by a surety bond issued by a bonding company licensed to do business in the state of Louisiana in the principal amount of \$5,000 (or such lesser amount as the secretary may permit upon request) conditioned to provide for payment of the costs of any investigation or hearing with respect to the application.

4. If the applicant is a corporation, the application shall also be accompanied by a certified copy of a resolution or resolutions of the board of directors of such applicant (and of any corporation controlling such applicant) specifically authorizing the person or persons signing the application and any consent on behalf of the applicant to sign and file the same.

C. Requirements as to Paper, Printing, and Language

1. The application shall be filed on good quality, unglazed, white paper, 8 1/2 by 14 inches in size, insofar as practicable.

2. The application and, insofar as practicable, all papers and documents filed as a part thereof, shall be printed, lithographed, mimeographed, or typewritten. All copies of applications and associated material shall be easily readable and suitable for repeated photocopying.

3. The application shall be in the English language. Any associated material filed with the application in a foreign language shall be accompanied by a translation into the English language.

D. Presentation of Information

1. Except as otherwise provided:

a. the application requires information only as to the applicant;

b. whenever words relate to the future, they have reference solely to present intention; and

c. any words indicating the holder of a position or office include persons, by whatever titles designated, whose duties are those ordinarily performed by holders of such positions or offices.

2. Unless clearly indicated otherwise, information set forth in any part of the application need not be duplicated elsewhere in the application. Where it is deemed necessary or desirable to call attention to such information in more than one part of the application, appropriate cross-references are permitted.

3. Material contained in any exhibit to the application may be incorporated by reference in the application. Such material shall be clearly identified in the reference, and an express statement that the specified matter is incorporated by reference shall be made at the particular place in the application where the information is required. Material shall not be incorporated by reference in any case where such incorporation would render the application incomplete, unclear or confusing.

4. Information need be given only insofar as it is known or reasonably available to the applicant. If any required information is unknown and not reasonably available to the applicant, either because the obtaining thereof would involve unreasonable effort or expense or because it rests within the knowledge of another person not affiliated with the applicant, the information may be omitted, subject to the following conditions.

a. The applicant shall give such information on the subject as he/she possesses or can acquire without unreasonable effort or expense, together with the sources thereof.

b. The applicant shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

5. The application shall set forth such additional material facts, if any, as may be necessary to make the required information, in the light of the circumstances under which it is provided, not misleading. The secretary may at any time request an applicant to submit additional relevant information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:131 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1727 (September 2015).

§517. Content of Application [Formerly LAC 43:I.917]

A. Each application shall contain the information required by Act 296 of 1979 and by this rule, §517.

1. Information as to the Lessee. Set forth the name of the lessee and the address of its principal executive offices and describe, insofar as practicable, the lease or leases of the lessee which it is proposed to transfer and the operations or

other activities currently being conducted in relation to such lease or leases.

2. Information as to the Applicant. If the applicant is a corporation, partnership, limited partnership, syndicate or other group of persons, the application shall set forth its name, the state or other place of its organization, its principal business, the address of its principal executive offices and the information required by Subparagraphs A.2.e and f below. If the applicant is natural person, the application shall set forth the information specified in Subparagraphs A.2.a-g below with respect to such person(s). If the applicant is a corporation not subject to the reporting requirements of the federal securities laws, there shall be filed as exhibits audited financial statements for its three most recent fiscal years and interim financial statements for any subsequent period through the end of the last preceding calendar quarter for which such statements are available:

a. name;

b. residence or business address;

c. present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment or occupation is conducted;

d. material occupations, positions, offices or employments during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which occupation, position, office or employment was carried on;

e. whether or not, during the last five years, such person has been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, giving the dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case;

f. whether or not the applicant has, during the last five years, been a party to, or materially adversely affected by, any judicial or administrative proceeding under any law or regulation regulating exploration, development, production or other operations involving any solid minerals or other extractive industry or activity, or under any law or regulation regulating the discharge of materials into the environment or otherwise relating to the protection of the environment, and if so, describing fully any such proceeding, including the disposition thereof. Copies of all material pleadings and of all orders and judgments therein shall be filed as exhibits;

g. citizenship(s):

i. instruction. If the application is filed by a partnership, limited partnership, syndicate or other group, the information called for by §517.A.2 shall be given with respect to:

(a). each partner of such partnership;

(b). each partner who is denominated as a general partner or who functions as a general partner of such limited partnership;

(c). each member of such syndicate or group;

and

(d). each person controlling such partner or member;

ii. if the statement is filed by a corporation, or if a person referred to in Subclause (a), (b), (c), or (d) of Clause A.2.g is a corporation, the information called for by the above mentioned items shall be given with respect to:

(a). each officer and director of such corporation;

(b). each person controlling such corporation;

and

(c). each officer and director of any corporation ultimately in control of such corporation.

3. Manner of Transfer. The application shall set forth the manner in which the applicant proposes to effect the transfer of the lease or leases (including, without limitation, the manner in which the transfer is to be financed and the terms of any agreement or understanding with respect to the transfer) and the applicant shall file as exhibits all relevant contracts and agreements, together with any documents required to be filed under any other law or regulation in consequence of such proposed transfer. The application shall also set forth a description of the background of the proposed transfer.

4. Information about the Applicant's Relevant Experience

a. The applicant shall fully describe his or its experience and capabilities to assume responsibility for operations under the lease or leases, including (without limitation) the following information.

i. Applicant's experience in the solid minerals and other extractive industries during the five years next preceding the application.

ii. If the applicant is other than a natural person, the names, titles and addresses of the officers or other persons who would have primary responsibility for the conduct of operations under the lease or leases and, as to each such person, his educational background, his professional background, including his present job responsibilities, and the information called for under Paragraph A.2 of this Section.

iii. The names and addresses of any expert in the field of expertise relevant to the lease or leases or operations thereunder who has been retained by the applicant at any time during the past five years and a statement of the nature of such retention. Copies of any report(s) rendered to the applicant by any such expert(s) shall be filed as exhibits.

b. Instruction. It is not sufficient compliance to recite the applicant's intention to rely upon the lessee's experience unless the applicant and lessee have entered into a formal written agreement for a term ending with or after the unexpired portion of the lease, under which the lessee will manage the property or properties subject to the lease. Any such agreement shall be filed as an exhibit to the application.

5. Plans of the Applicant with Respect to the Lease. The application shall describe any plans or proposals of the applicant which relate to exploration, development, production or other operations under the lease or leases, including, without limitation, any loan or proposal to do the following:

a. to increase, reduce or abandon such operations;

b. to retain any person to conduct such operations;

- c. to transfer the lease or leases;
- d. to seek modification of its or their terms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:132 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1727 (September 2015).

§519. Exhibits

[Formerly LAC 43:I.919]

A. Additional Exhibits. The applicant may file such exhibits as he/she may desire in addition to those required under §517. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer.

B. Omission of Substantially Identical Documents. In any case where two or more contracts, or other documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, the applicant need file a copy of only one of such documents, with a schedule identifying the other documents omitted and setting forth the material details in which such documents differ from the document of which a copy is filed. The secretary may at any time, in his discretion, require the filing of copies of any documents so omitted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1729 (September 2015).

§521. Amendments

[Formerly LAC 43:I.921]

A. Formal Requirements for Amendments. One copy of each amendment to an application shall be filed with the secretary, and delivered by hand to the lessee, promptly upon the occurrence of the event necessitating such amendment.

B. Withdrawal of Application or Amendment. Any application or any amendment or exhibit thereto may be withdrawn upon written request to the secretary. The request shall be signed and shall state the grounds upon which made. The request shall be deemed granted five days after receipt by the secretary, unless he shall order conditions to the grant thereof, in which event withdrawal will be effective upon written notice to him of compliance therewith. If an application is withdrawn, the examination fee paid upon the filing of the application will not be returned. The papers comprising any withdrawn application or amendment or exhibit thereto shall not be removed from the files of the secretary but shall be retained therein.

C. Powers to Amend or Withdraw Application. All persons signing an application shall be deemed, in the absence of a statement to the contrary, to possess the following powers:

- 1. to amend the application; or
- 2. to request the withdrawal of an application, an amendment or an exhibit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1729 (September 2015).

§523. Application for Determination without Investigation or Hearing

[Formerly LAC 43:I.923]

A. An application filed in compliance with these rules may be accompanied by a request that the secretary transmit a recommended decision on the application to the board without first conducting an investigation or holding a hearing. Any such request shall be signed by or on behalf of the applicant and be accompanied by affidavits from each of:

- 1. the applicant (or an officer of the applicant); and
- 2. the lessee (or an officer of the lessee) stating that in

their opinion there are no substantial issues requiring an investigation or hearing. In the event such request is denied, the applicant shall promptly thereafter file the surety bond required by §515.B.3.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), repromulgated by the Department of Natural Resources, Office of Mineral Resources, LR 41:1729 (September 2015).

Subchapter C. Royalty Crude Oil

§525. Purpose

[Formerly LAC 43:I.925]

A. It is the purpose of these regulations, and in the best interest of the state, to establish a program to provide a mechanism for taking state royalty oil volumes in kind and for the disposition by sales or processing contracts, in a fair and equitable manner, of available supplies of such state royalty oil to eligible refiners within the state, with the intent thereby to increase the supplies of gasoline, diesel or other fuel products available to Louisiana citizens.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:142.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:256 (February 2008), repromulgated LR 41:1729 (September 2015).

§527. Definitions

[Formerly LAC 43:I.927]

Affiliates—any business concerns affiliated with each other where either directly or indirectly one concern controls or has the power to control the other or a third party controls or has the power to control both.

Contract—a contract for the disposition of state royalty oil.

Lessee—the owner or owners of the working interest under a state lease.

Lessor—the state of Louisiana acting through the State Mineral Board.

Louisiana Refiner—an applicant who is certified by the mineral board.

Refiner—a qualified applicant who contracts for state royalty oil pursuant to the policies and procedures established by the State Mineral Board and these regulations.

Royalty Oil—the state's royalty portion of crude oil or condensate produced from or allocated to state leases.

Seller—the State Mineral Board acting on behalf of the state of Louisiana in a contract to sell royalty oil.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:256 (February 2008), repromulgated LR 41:1729 (September 2015).

§529. Policies and Procedures of the State Mineral Board
[Formerly LAC 43:I.929]

A. Royalty oil available through exercise of the state's right to take in kind shall be disposed of pursuant to policies and procedures approved by the State Mineral Board, which shall be consistent with the intent and purpose of R.S. 30:143 and these regulations.

B. Prior to the execution of any contracts by the State Mineral Board, and pending a determination of available supplies, the Office of Mineral Resources, under the direction of the Secretary of the Department of Natural Resources, shall prepare for board consideration recommendations for the disposition of available state royalty oil. Such recommendations shall address the sale and accounting of royalty oil; processing and accounting for royalty oil; and public bidding and accounting for royalty oil.

C. The Office of Mineral Resources shall prepare a projection of the costs of administering the program as well as a recommendation to the board of the amount of administrative fee, not to exceed \$0.20 per barrel, necessary to cover such costs, and if applicable, the minimum volume of royalty oil which must be included in each type of transaction to be cost efficient.

D. In accomplishing the purposes of the Section, the Office of Mineral Resources shall be authorized to consult with such industry, government and professional persons as may be necessary. Within the limitations of its budget, or utilizing funds made available for that purpose, the office may contract for any professional services necessary, subject to the approval of the Secretary of the Department of Natural Resources.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:133 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:256 (February 2008), repromulgated LR 41:1730 (September 2015).

§531. Inventory; Delivery Points; Objections
[Formerly LAC 43:I.931]

A. For each lease, division order or other legal instrument pursuant to the terms of which the state has a royalty oil interest susceptible of taking in kind, the Office of Mineral Resources shall determine the volumes and prices applicable to such royalty.

B. The Office of Mineral Resources shall notify each of the state's lessees of the state's interest in taking in kind the volume of state royalty oil attributable to the production of each such lessee, requesting the designation, within 30 days, of proposed delivery points therefore, and notice of any perceived impediments, objections or hardships with regard to such taking under a particular lease or other legal instrument.

C. Impediments or objections which cannot be resolved within 60 days of notice, by informal conference with the State Mineral Board, shall be referred to the Secretary of the

Department of Natural Resources for his review and disposition by such procedures as he may deem appropriate and in the best interest of the state.

D. The lease volumes, prices and proposed delivery points for all state royalty oil for which there is no unresolved impediment or objection to taking in kind, shall be compiled by the Office of Mineral Resources for submission to the State Mineral Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:134 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:257 (February 2008), repromulgated LR 41:1730 (September 2015).

§533. Louisiana Refiner Criteria
[Formerly LAC 43:I.933]

A. To be eligible to purchase or process state royalty crude oil an applicant therefore must be certified by the State Mineral Board as a Louisiana refiner.

B. To qualify as a Louisiana refiner, an applicant to purchase or process state royalty crude shall meet all of the following criteria.

1. Applicant shall be a Louisiana business entity having its principal place of business in the state of Louisiana. In applying this criterion, principal place of business shall mean:

a. 51 percent of the applicant's and all affiliates' total refining capacity is located in Louisiana; or

b. Louisiana is the applicant's state of incorporation;

or

c. applicant's headquarters or corporate offices and at least 51 percent of its officers and employees are located in Louisiana.

2. Applicant shall have facilities in the state with available capacity for refining or processing crude oil or condensate into fuel products and/or the capability for the distillation of methanol or ethanol suitable for blending with gasoline to produce a motor fuel.

3. Applicant must have adequate facilities to receive crude oil and own or have contractual rights to use facilities for storage of royalty crude oil and for storage or products refined therefrom.

4. Applicant must be able to:

a. legally condition the sale of products refined from the state royalty oil upon the right of the state to exercise a right of first refusal to any such products; and

b. to give first priority to Louisiana customers in the usual course of sale of such products.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:134 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:257 (February 2008), repromulgated LR 41:1730 (September 2015).

§535. Application Requirements
[Formerly LAC 43:I.935]

A. A refiner desiring to purchase or process state royalty oil shall file an application with the Office of Mineral Resources with an original and 10 copies containing the following information:

1. the full name and address of the applicant;

2. a detailed statement showing the applicant's qualifications to be certified a Louisiana refiner pursuant to §933 of these regulations, attested to by affidavit;

3. the capacity of the refinery to be supplied;

4. a tabulation for each of the last 12 months of operation, or since start-up date if less than 12 months, or projection for the next 12 months, of refining capability, of the amount of the thru-put capacity, the source and grades of crude oil refined or refinable, and the kind, amount and percentage of the principle fuel products produced;

5. if applicable, the amount and source of methanol and ethanol production available to applicant including identification of the sources of agricultural products used to produce such methanol and ethanol;

6. a plan of procedure setting forth in detail the mechanisms proposed to be employed to dispose of refined products in the state and to accommodate the state in the event that it exercises its rights of first refusal, together with any approvals from the federal government which may be necessary to carry out such disposition;

7. a complete disclosure of applicant's affiliation, and the nature thereof, with any other producer and refiner;

8. the minimum amount of royalty oil requested and the state lease or leases applicant believes offer a potential source of royalty oil, if known;

9. a list of all customers to whom products were sold in the current and previous year and all customers required to be supplied pursuant to federal law or regulations, including such customer's address and type of products purchased;

10. a contingency plan for handling of the state's royalty crude in the event that a force majeure event occurs disrupting normal operations;

11. such other information as the State Mineral Board may by appropriate notice require for such applications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:134 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:257 (February 2008), repromulgated LR 41:1730 (September 2015).

§537. Disposition; Approval; Priority
[Formerly LAC 43:I.937]

A. Royalty crude shall normally be made available to qualified applicants based upon each qualified applicant receiving an equal proportionate share of the total royalty crude oil available. The State Mineral Board may establish policies and procedures for alternate methods of disposition of royalty crude not otherwise subject to public bid, and for public bidding for royalty crude not subject to price controls when the board deems such alternate methods are appropriate. In either case the board may establish such conditions as it deems necessary, in addition to the conditions set forth in these regulations, to protect the interests of the state and to provide, to the extent practicable, for fair and equitable allocation.

B. Prior to implementing procedures for public bidding, and prior to disposing of royalty crude by a contract, for the sale or processing thereof, the board shall present such procedures, and each such contract, to the House and Senate Committees on Natural Resources, meeting jointly, for approval thereof.

C. The board shall incorporate in its policies and procedures mechanisms which give first priority to eligible refiners with capability to refine typical south Louisiana, light sweet type crude and refiners with operable facilities for the distillation of methanol or ethanol suitable for blending with gasoline to produce a motor fuel. The board shall develop procedures for ranking refiners with facilities for the distillation of methanol or ethanol according to the percentage of Louisiana agricultural products used in such refiners' distillation process, with those refiners deriving ethanol or methanol by using 50 percent or more of Louisiana agricultural products ranked first. Refiners using less than 10 percent Louisiana agricultural products shall not be entitled to ranking in this first priority.

D. No refiner shall be entitled to receive more than 7,500 barrels per day of state royalty crude.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:134 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:258 (February 2008), repromulgated LR 41:1731 (September 2015).

§539. Contract Term; Renewal; Minimum Requirements
[Formerly LAC 43:I.939]

A. The term of any contract entered into by the board with a qualified refiner for the purchase or processing of state royalty crude oil shall have a maximum primary term of no more than three years. Such contract shall be renewable upon timely application of the same conditions, or such additional conditions as may be deemed necessary to serve the best interest of the state, at the sole discretion of the board.

B. Intention of the refiner to seek renewal of a contract shall be evidenced by written application filed no later than 60 days prior to the expiration date of the contract then in effect.

C. If the board does not receive written application for renewal within the time set forth in Subsection B, the board may readvertise the availability of the volume of royalty crude oil committed under such contract and enter into a new contract with a qualified refiner effective upon the expiration date of the unrenewed contract, or make such other disposition of the royalty oil as it determines to be in the best interest of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:135 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:258 (February 2008), repromulgated LR 41:1731 (September 2015).

§541. Transportation; Delivery; Storage; Transportation Costs; Minimum Requirements
[Formerly LAC 43:I.941]

A. In any contract, the refiner shall be responsible to arrange with the state's lessee for the delivery and receipt of all royalty oil.

B. The point of delivery for royalty oil under any contract shall be the field where produced or a site as near as possible to the point of delivery normally utilized by the

state's lessee for delivery of crude oil when state's royalty share is not taken in kind.

C. The refiner shall promptly reimburse state's lessee for the cost of transporting crude oil to the point of delivery at the rate set by the applicable state lease for deductions from royalties for the costs of transportation. If no such rate for deductions is set by the applicable state lease, the refiner shall reimburse the lessee at a rate to be approved by the State Mineral Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:135 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:258 (February 2008), repromulgated LR 41:1731 (September 2015).

§543. Price; Deductions; Method of Payment; Reports; Taxes; Administrative Fee
[Formerly LAC 43:I.943]

A. The price to be paid by a refiner pursuant to any contract for the purchase of royalty crude oil shall be the maximum price allowed pursuant to the applicable and controlling federal or state law on the effective date of the contract. In the event that such price controls are terminated during the term of a contract, the price to be paid by a refiner shall be the fair market value of the state's royalty oil, which condition shall be effective at any time while the contract is in effect.

B. In calculating the payments for royalty crude oil purchased, the refiner may deduct from the price that portion of the transportation costs reimbursed to the state's lessee which represents the actual cost of transportation to the agreed upon point of delivery utilized. Any additional cost of transportation for delivery to a more distant point shall be borne solely by the refiner.

C. Payments due under any contract shall be made monthly, such payments to be consistent with the volume of royalty oil received by the refiner during such preceding month.

D. The refiner shall be required to file monthly reports with the Office of Mineral Resources setting forth by lease and delivery point all volumes of crude oil received.

E. The state shall assume responsibility for all severance taxes due on its royalty production in effect on the contract date. The refiner shall be liable for all other taxes and any additional or increased taxes which become effective following the date of the contract. The board may require the refiner to advance or remit to the appropriate state lessee all severance taxes paid by such lessee which are attributable to the volume of royalty oil acquired by the refiner. In such event the refiner shall be entitled to deduct such taxes on a monthly basis from payments due the state and remit same to the appropriate state lessee.

F. In addition to all other prices, fees, and charges otherwise authorized in these regulations, the board may assess a fee not in excess of \$0.20 per barrel of royalty oil delivered to cover the cost of administration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:135 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:258 (February 2008), repromulgated LR 41:1732 (September 2015).

§545. Utilization; Right of First Refusal; Assignment; Resale

[Formerly LAC 43:I.945]

A. Refiner shall not resell any royalty crude oil without the prior written consent of the mineral board.

B. All royalty crude oil sold or processed under any contract, or other crude oil received in lieu of royalty crude oil under an exchange agreement, shall be utilized at refiner's facilities in the state and shall not be used for resale in kind except as authorized by the provisions of this Section. To the extent permitted by controlling federal law or regulations no gasoline or diesel end product refined from state royalty crude under any contract shall be sold for the ultimate purpose of retail sale outside of the state of Louisiana.

C. The resale or exchange of royalty crude oil in violation of the provisions of this Section shall be punishable by a fine of not less than \$10,000 per day for each day of violation.

D. Any contract for the sale or processing of state royalty oil shall be conditioned upon the right of the state to exercise a right of first refusal to any product refined from the royalty crude.

E. Any contract for the sale or processing of state royalty oil shall also require that first priority be given to Louisiana customers in the usual course of sale of end products.

F. Refiner shall be required to furnish the board copies of all contracts entered into between refiner and third parties reflecting delivery, receipt, handling, transporting, sale and use of crude oil covered by a contract with the board, or refined products derived therefrom.

G. No contract shall be assignable without the prior written consent of the board.

H. Refiner shall not enter into any exchange agreement whereby other crude oil in lieu of the state's royalty crude oil is delivered to refiner without the prior written consent of the mineral board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:135 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:259 (February 2008), repromulgated LR 41:1732 (September 2015).

§547. Penalties; Liability; Bond
[Formerly LAC 43:I.947]

A. The board shall provide for the assessment of a late charge at the rate of 7 percent per annum on any payments received from the refiner after the date such payments are due as otherwise provided in these regulations.

B. In any contract for the disposition of royalty crude oil, the board shall assure that the state is held free and harmless from any liability, cost or expense arising from the execution of such contract or from the delivery of any crude oil pursuant thereto. The refiner shall assume all liability for the actions of itself, its agents and employees, and of the state's lessee, its agent and employees in receiving delivery, handling, transporting and refining of royalty oil.

C. Prior to the disposition of any royalty crude oil as provided herein, the board shall require each refiner to furnish to the state a letter of credit from an established and recognized bank within the state, or an acceptable surety bond, in an amount equal to the price and administrative fee

for 45 days volume of crude oil to be delivered under any contract, or \$500,000, whichever amount is less, guaranteeing good and faithful performance of the terms and conditions of these regulations and any contract. The full amount of such letter of credit or bond, or any portion thereof, may be applied to any sums or damages due the state as a result of the breach of any condition of the contract or violation of these regulations. Such right shall be in addition to any other legal rights and remedies available to the state. The board shall reserve the right to require the increase in the amount of this security when necessary to protect the interest of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:135 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:259 (February 2008), repromulgated LR 41:1732 (September 2015).

§549. Warranties; Governmental Regulations

[Formerly LAC 43:I.949]

A. In any contract the board shall not warrant the crude oil delivered as being merchantable or suitable for refiner's purpose and the board shall not be liable for the quality of the crude oil or the content thereof. The board shall not warrant to refiner that there are available sufficient quantities of royalty crude oil from any state lease(s) dedicated to a contract to meet refiner's requirements.

B. All contracts shall be subject to applicable state, local and federal laws, rules and regulations. Refiner shall be required to secure all licenses, permits, orders, or waivers necessary for the performance of the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:136 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:259 (February 2008), repromulgated LR 41:1733 (September 2015).

§551. Additional Procedural Rules

[Formerly LAC 43:I.951]

A. The board may from time to time adopt such additional policies and rules of procedures as are deemed necessary to fully effectuate and administer the regulations set forth herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:143.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of the Secretary, LR 6:136 (March 1980), amended by the Department of Natural Resources, Office of Mineral Resources, LR 34:259 (February 2008), repromulgated LR 41:1733 (September 2015).

Chapter 7. Leasing State Lands and Water Bottoms for the Exploration, Development and Production of Wind Energy

Editor's Note: Pursuant to Act 196 of the 2009 Regular Session, the name of the State Mineral Board has been changed to State Mineral and Energy Board.

§701. Authority

[Formerly LAC 43:I.1001]

A. These rules and regulations are promulgated by the Secretary of the Department of Natural Resources pursuant to the Administrative Procedure Act as authorized by R.S. 41:1734.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), repromulgated LR 41:1733 (September 2015).

§703. Purpose

[Formerly LAC 43:I.1003]

A. These rules and regulations are promulgated for the following purposes:

1. to implement the provisions of and accomplish the intent of the legislature as set forth in Chapter 14-A of Title 41 of the Louisiana Revised Statutes of 1950;

2. to establish procedures for state wind lease acquisition, transfer, release, operations, electric power production royalty payment and reporting, and decommissioning;

3. to institute reasonable fees for services performed by the Department of Natural Resources.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), repromulgated LR 41:1733 (September 2015).

§705. Overview of the State Wind Lease Acquisition Process

[Formerly LAC 43:I.1005]

A. Leases for the exploration, development and production of wind energy on state lands and water bottoms under Chapter 14-A of Title 41 of the Louisiana Revised Statutes of 1950 shall be acquired from the State Mineral Board in conjunction with the Secretary of the Department of Natural Resources, through the Office of Mineral Resources, through a public bid process as set forth in this Chapter. There are nine general steps in the state wind lease acquisition process as outlined below. Each general step has its own set of procedures which are outlined in detail in separate Sections of this Chapter:

1. registration;
2. pre-nomination research;
3. nomination of state lands and water bottoms for wind lease;
4. examination and evaluation of nomination for state wind lease;
5. advertisement of state tract offered for wind lease and request for bids;
6. submission of bids on state tract offered for wind lease;
7. examination and evaluation of bids for state wind lease;
8. award of state wind lease;
9. issuance and execution of state wind lease contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), repromulgated LR 41:1733 (September 2015).

§707. Registration

[Formerly LAC 43:I.1007]

A. Applicant Registration. Any party who wants to apply for a state wind lease shall register certain information with the Office of Mineral Resources on a one-time basis prior to submitting an application. Registration consists of

completing and submitting an official Applicant Registration Form.

1. **Prospective Leaseholder Registration.** All prospective leaseholders of state wind leases shall register certain information and proof of current authorization to do business in the state of Louisiana with the Office of Mineral Resources and thereafter renew their registration annually by January 31. Only those bidders who are registered as prospective leaseholders with the Office of Mineral Resources shall be allowed to bid on tracts for the purpose of obtaining a state wind lease. Transfers or assignments of state wind leases shall not be granted to prospective leaseholders that are not currently registered as a prospective leaseholder with the Office of Mineral Resources.

a. Registration consists of submitting a completed official prospective leaseholder registration form (obtainable from the Office of Mineral Resources) and an appropriate certificate from the Louisiana Secretary of State to the Office of Mineral Resources as follows:

- i. individual/sole proprietorship—no certificate required;
- ii. corporation—good standing certificate;
- iii. limited liability company—good standing certificate; and
- iv. partnership—existence certificate.

b. If a current record state wind lessee fails to maintain his Prospective Leaseholder Registration with the Office of Mineral Resources, the State Mineral Board may levy liquidated damages of \$100 per day until the unregistered lessee is properly registered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), repromulgated LR 41:1733 (September 2015).

§709. Pre-Nomination Research [Formerly LAC 43:I.1009]

A. A party seeking to nominate state lands or water bottoms for wind lease shall conduct research prior to nomination to determine and confirm whether the state lands or water bottoms fall under one of the following six categories and comply with any category requirements.

1. **Louisiana Wildlife and Fisheries Commission/Louisiana Department of Wildlife and Fisheries Property.** The lands and water bottoms in this category are under the jurisdiction of the Wildlife and Fisheries Commission or the Department of Wildlife and Fisheries, including but not limited to, wildlife management areas and refuges. Questions concerning these lands and water bottoms should be directed to the Louisiana Department of Wildlife and Fisheries, Office of Wildlife, Fur and Refuge Division.

2. School Indemnity Lands
3. Tax Adjudicated Lands
4. Vacant State Lands
5. White Lake

6. **Legal Areas.** Title to certain state lands or water bottoms may have been established by compromise without litigation, compromise during the course of litigation, or adjudication in a court of law. For state wind leasing purposes, state lands or water bottoms subject to such compromise or adjudication are viewed as a "Legal Area." Determine whether the state lands or water bottoms to be nominated include a legal area. If they do, the nominating

party shall provide a copy of the compromise instrument(s) or judgment(s) that establish(es) the state ownership interest.

Questions concerning categories 2 through 6 should be directed to the State Land Office, Division of Administration.

B. A party seeking to nominate state lands or water bottoms for wind lease shall conduct research prior to nomination to determine and confirm that the state lands or water bottoms are available for wind lease. The following are some conditions indicating availability.

1. The State Mineral Board has not taken the state lands and water bottoms out of commerce for the purpose of wind leasing.

2. The state lands and water bottoms are subject to an active or non-released land use agreement granted by the state of Louisiana and the user under such an agreement has been notified of the proposed wind leasing.

a. The nominating party shall provide proof of notification consisting of a complete list of the users of the state lands and water bottoms to be nominated for wind lease, the official name and/or number of the governing land use agreement, the official name of the state entity that granted the governing land use agreement, along with an affidavit sworn to by the nominating party, in the presence of a notary and two witnesses, confirming that the party has notified each of the listed users of the state lands and water bottoms of the proposed wind leasing. The nominating party shall follow the notarization requirements of R.S. 35:12.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), repromulgated LR 41:1734 (September 2015).

§711. Nomination of State Lands and Water Bottoms for Wind Lease [Formerly LAC 43:I.1011]

A. Interested, registered parties shall nominate state lands and water bottoms for wind lease by scheduling a pre-nomination meeting with and submitting proposals (called "nominations") by application to the Office of Mineral Resources in the form it requires. Each application shall include a description of the land, including a map, on both paper and diskette or CD-ROM, and be accompanied by submission of a nonrefundable \$400 processing fee made payable to the Office of Mineral Resources, as well as any other documentation and information required.

B. Only those parties who are registered applicants with the Office of Mineral Resources as set forth under §1007.A shall be allowed to nominate state lands and water bottoms for wind lease.

C. A party interested in nominating state lands and water bottoms for wind lease shall observe the following restrictions.

1. Use bearing, distance and X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), to accurately and clearly describe the nominated acreage. Determine whether the acreage to be nominated falls in the North Zone or the South Zone of the Louisiana Coordinate System of 1927 and provide this information in the nomination packet. A single nomination may contain acreage that falls partially in the North Zone and partially in the South Zone. However, allocate the nominated acreage to the zone wherein the majority of the acreage falls and use that zone's coordinates (see R.S. 50:1).

a. A nominating party is excepted from using the Louisiana Coordinate System of 1927 only if the acreage to be nominated is not susceptible of or has another type legal description not translatable into a description using bearing, distance and X-Y coordinates based on the Louisiana Coordinate System of 1927. If the acreage to be nominated falls under this exception, the nominating party is allowed to provide the legal description of the property as provided in the title deed wherein the state acquired its ownership interest in the property.

2. Nominate 5,000 acres or less of state lands and water bottoms for state wind lease in a single nomination.

3. Delineate the nominated acreage by a square or rectangle only, no side of which shall be greater than 3 1/2 half miles 18,480.00 feet in length.

a. A nominating party is excepted from delineating the nominated acreage by a square or rectangle when the nominated acreage abuts the Three Mile Line as decreed by the United States Supreme Court in *United States v. State of Louisiana et al.* In this situation, use a polygon as close in shape to a square or rectangle as is practical.

D. A party interested in nominating state lands and water bottoms for wind lease shall schedule a pre-nomination meeting with the Office of Mineral Resources, at which meeting the party shall submit a nomination packet that includes one copy (unless required otherwise) of the following items:

1. an official letter of application for a state wind lease available from the Office of Mineral Resources. Provide three originally signed paper copies and no electronic copy;

2. any title documentation obtained pursuant to §709.A.6;

3. any proof of notification documentation obtained pursuant to §709.B.2;

4. a written property description of the nominated acreage, fully justified, using Microsoft Word. Provide three original paper copies and one electronic copy as a Word .doc file on the nomination diskette or CD-ROM. Include:

a. a designated point of beginning using X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), then going clockwise fully write out (no abbreviations or symbols) bearing and distance to the next X-Y coordinates for each corner back to the point of beginning;

b. the gross acreage amount of state lands and water bottoms, inclusive of Louisiana Wildlife and Fisheries Commission/Louisiana Department of Wildlife and Fisheries Property, contained within the nomination area;

c. the net acreage amount of state lands and water bottoms, exclusive of Louisiana Wildlife and Fisheries Commission/Louisiana Department of Wildlife and Fisheries property, contained within the nomination area; and

d. the net acreage amount of Louisiana Wildlife and Fisheries Commission/Louisiana Department of Wildlife and Fisheries property contained within the nomination area;

5. a plat of the nominated acreage, using the most recent background imagery. Use X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable). Provide three original paper copies and one electronic copy as a .pdf file on the nomination diskette or CD-ROM. Include:

a. an outline of the nominated acreage with a designated point of beginning and corners using X-Y coordinates that exactly match the X-Y coordinates for the point of beginning and corners provided in the written property description, clearly labeled therein;

b. an outline of the state lands and water bottoms falling in the nomination area, clearly labeled along with the acreage amount contained therein;

c. an outline of any Louisiana Wildlife and Fisheries Commission/Louisiana Department of Wildlife and Fisheries property, school indemnity lands, tax adjudicated lands, vacant state lands, White Lake, and legal areas, falling in the nomination area, clearly labeled along with the acreage amount contained in each;

d. an outline of each active or non-released land use agreement granted by the state of Louisiana including, but not limited to, a state wind lease, state mineral lease, state operating agreement, state exclusive geophysical agreement, state non-exclusive seismic permit, state right of way, and/or state surface/subsurface agreement, as well as any nomination tract approved for advertisement or advertised as offered for state mineral lease, state operating agreement, or state exclusive geophysical agreement abutting, adjacent to, intersecting, and partially/wholly enclosed in the nomination area, clearly labeled with its official number along with the acreage amount contained therein;

e. an outline of any lands and water bottoms not belonging to the state of Louisiana falling in the nomination area, clearly labeled "Not State Owned" along with the acreage amount contained therein;

f. all water bodies, clearly labeled;

g. the block system (if applicable), with block names and numbers;

h. section, township, range information (if applicable);

i. parish name(s); and

j. the name and date of the background imagery used;

6. a .dxf file that contains only the boundary of the nominated acreage, provided on the nomination diskette or CD-ROM. The boundary shall be a single line with no additional lines, labels, text, or graphics, and shall be constructed of individual line segments between vertices. The X-Y coordinates in the .dxf file must exactly match those in the written property description and the plat;

7. a nomination diskette or CD-ROM clearly labeled "State Wind Lease Nomination Diskette" that shall have the applicant and project names affixed thereon and contain the written property description as a Word .doc file, the plat as a .pdf file, and the .dxf file;

8. a summary of the environmental issues including, but not limited to, avian and baseline noise levels, the environmental impact of the placement of wind turbines and other equipment necessary for the exploration, development and production of wind energy, and the steps proposed to minimize the environmental impact, along with any supporting environmental impact documentation;

9. a list of governmental entities including each federal, state, parish and local governmental entity that has jurisdiction in the nomination area and for each, the contact

person name, title, office address, telephone and fax numbers, and email, as well as the type of legal authority, if any, acquired or to be acquired from the governmental entity;

10. a nomination fee payment in the amount of \$400 made payable to the Office of Mineral Resources as a non-refundable fee to satisfy the cost of processing an application for a state wind lease. A personal or business check is acceptable;

11. any other information and documentation required by the Office of Mineral Resources.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:261 (February 2008), repromulgated LR 41:1734 (September 2015).

§713. Examination and Evaluation of Nomination for Wind Lease
[Formerly LAC 43:I.1013]

A. If the Office of Mineral Resources determines that the state wind lease nomination complies with legal, procedural and technical requirements, as well as with any current policies and practices, it shall:

1. place the state wind lease nomination tract on the State Mineral Board's Tract Evaluation Committee agenda for the next regular board meeting;

2. take the area out of commerce for the purpose of wind leasing while the nomination is being evaluated;

3. transmit a copy of the letter of application for a State Wind Lease, written property description, and plat to the State Land Office and to the Louisiana Department of Wildlife and Fisheries, who shall review the proposed location of the state wind lease, certify to the State Mineral Board whether or not there are other leases of any kind at the proposed lease location and if so, provide copies to the State Mineral Board of the other leases as an attachment to the other leases certification; and

4. transmit the nomination packet and the other leases certifications to the Secretary of the Department of Natural Resources for evaluation.

B. The Secretary of the Department of Natural Resources shall evaluate the wind lease nomination pursuant to R.S. 41:1733.B and determine whether the proposed wind lease is appropriate. If so, he shall recommend to the State Mineral Board that it conduct a public bid process and if not, he shall recommend to the State Mineral Board that it not conduct a public bid process. The State Mineral Board, through the Office of Mineral Resources, shall notify the applicant of the secretary's determination via a bid process determination letter.

C. If an applicant wants to withdraw a nomination during the examination and evaluation process, prior to the tract being officially advertised for a state wind lease, he shall submit a letter requesting withdrawal of the nomination to Office of Mineral Resources, Attention: Leasing Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:262 (February 2008), repromulgated LR 41:1736 (September 2015).

§715. Advertisement of State Tract Offered for Wind Lease and Request for Bids
[Formerly LAC 43:I.1015]

A. The State Mineral Board, through the Office of Mineral Resources, shall publish an advertisement of the state tract offered for wind lease and request for bids in the official journal of the state and official journal(s) of the parish(es) where the lands are located, and otherwise at its discretion, not more than 120 days and not less than 60 days prior to the date for the public opening of bids (generally the lease sale date). The advertisement shall contain a description of the land proposed to be leased and its official tract number, any notes pertaining to the nominated tract, the date, time and place where sealed bids shall be received and publicly opened, a statement that a bid shall only be for the whole of the land advertised and no portion bids will be accepted, the minimum dollar amount (bonus) and minimum electric power production royalty to be demanded, and any other information the board may consider necessary. This advertisement and any other published by the board shall constitute judicial advertisement and legal notice within the contemplation of R.S. Title 43, Chapter 5.

B. The advertisement shall also provide notice of the following.

1. A party shall bid on the whole of the land advertised. A portion bid shall not be accepted.

2. A wind lease on state lands and water bottoms shall have a primary term of five years.

3. The dollar amount (bonus) with regard to any wind lease on state lands and water bottoms shall be no less than the minimum amount set by the State Mineral Board. The dollar amount shall be provided on the official bid form as a total amount and as an amount per acre (which is equal to the dollar amount divided by the acreage bid on). The dollar amount (bonus) bid shall be due within 24 hours of state wind lease award. Payment shall be made to the Office of Mineral Resources via certified funds or wire transfer. If payment is not made the State Mineral Board may not execute the lease and may rescind it.

4. The annual rental with regard to any wind lease on state lands and water bottoms shall not be for less than one-half of the dollar amount (bonus).

5. The electric power production royalty with regard to any wind lease on state lands and water bottoms shall be no less than the minimum amount set by the State Mineral Board of the lessee's gross revenues. The state may elect, at its option, to take in kind all or any of the portion due it as royalty.

6. A bidder for a state wind lease may offer additional consideration.

7. When two or more parties submit a joint bid, the parties shall designate the undivided percent interest of each party on the official bid form. The interests so designated shall be stipulated in any lease that may be awarded. Failure to designate the undivided percent interest of each joint bidder shall result in the State Mineral Board assigning equal interests to each bidder.

8. When two or more parties submit a joint bid, the parties shall designate the party who shall be the principal

state wind lessee, authorized to act on behalf of all co-lessees, on the official bid form. Additionally, each party shall submit a designation of principal state wind lessee and operator form with the joint bid. The principal state wind lessee and operator so designated shall be stipulated in any lease that may be awarded.

9. A state wind lease shall not be for more than 5,000 acres.

10. The State Mineral Board is authorized to collect an administrative fee for leasing state lands and water bottoms for the exploration, development and production of wind energy in the amount of 10 percent of the total dollar amount (bonus) bid for a state wind lease. This 10 percent administrative fee shall be in addition to the total dollar amount bid and is due within 24 hours of state wind lease award. Payment shall be made to the Office of Mineral Resources via certified funds or wire transfer. If payment is not made the State Mineral Board may not execute the lease and may rescind it.

11. A bid for a state wind lease shall exclude all rights not specifically granted in any wind lease awarded.

12. Once a bid is submitted, it may not thereafter be withdrawn or cancelled. The State Mineral Board does not obligate itself to accept any bid. Bid acceptance or rejection is at the sole discretion of the State Mineral Board which reserves the right to reject any and all bids or to grant a wind lease on any portion of the state tract advertised and to withdraw the remainder of the tract.

13. If examination of the successful bid acreage amount reveals that there is more or less state acreage than the amount bid on, then the dollar amount (bonus) and annual rental shall be adjusted accordingly.

14. The successful bidder(s) to whom a state wind lease is awarded has 20 days from receipt of the lease contract, properly executed by the State Mineral Board, to execute and return the lease contract to the Office of Mineral Resources. Failure to return the lease contract, properly executed, within 20 days may result in forfeiture of the state wind lease including the dollar amount (bonus) and 10 percent administrative fee.

15. All state wind leases shall be executed upon the terms and conditions provided in the current official state wind lease form with any attached rider(s).

16. Notwithstanding any provisions to the contrary in any state wind lease awarded or in any rider attached thereto, the lease awarded shall be granted and accepted without any warranty of title and without any recourse against the lessor whatsoever, either expressed or implied. Further, lessor shall not be required to return any payments received under the state wind lease awarded or be otherwise responsible to the state wind lessee therefor.

17. Some tracts available for wind leasing may be situated in the Louisiana Coastal Zone as defined in R.S. 49:214.21 et seq., and may be subject to guidelines and regulations promulgated by the Louisiana Department of Natural Resources, Office of Coastal Restoration and Management, Coastal Management Division, for operations in the Louisiana Coastal Zone.

18. Lessor excepts and reserves the full use of the leased premises and all rights with respect to its surface and subsurface for any and all purposes except for those granted to the state wind lessee, including the use of the leased

premises for the exploration, production and development of oil, gas and other minerals by the lessor, its mineral lessees, grantees or permittees. Co-users of the leased premises shall agree to coordinate plans and cooperate on activities to minimize interference with other operations to the extent possible.

19. Any and all wind data collected by the state wind lessee during the primary term of the lease shall become public record at the end of the primary term.

20. Any contract entered into for the lease of state lands for any purpose shall require that access by the public to public waterways through the state lands covered by the lease shall be maintained and preserved for the public by the lessee. This provision shall not prohibit the secretary of the agency having control over the property from restricting access to public waterways if he determines that a danger to the public welfare exists. This provision shall not apply in cases involving title disputes.

21. Prior to commencing construction, each state wind lessee and state wind lease operator shall have a general liability insurance policy in a form acceptable to the State Mineral Board as set forth in §729.A.2.

22. Prior to commencing construction, each state wind lessee and state wind lease operator shall provide financial security in a form acceptable to the State Mineral Board as set forth in §729.A.3.

23. The state wind lessee and state wind lease operator shall be required, in the state wind lease contract, to take measures to reduce risk to the state, including but not limited to, effecting compliance with any and all wind energy standards established by the American National Standards Institute (ANSI), the American Wind Energy Association (AWEA), the International Electrotechnical Commission (IEC), and any other entity responsible for establishing wind industry consensus standards. Standards for wind energy development/operations include, but are not limited to:

- a. wind turbine safety and design;
- b. power performance;
- c. noise/acoustic measurement;
- d. mechanical load measurements;
- e. blade structural testing;
- f. power quality; and
- g. siting.

C. A party may request proof that a tract was advertised in the official state and parish journals using the official Request for Proof of Publication form published by the Office of Mineral Resources. Proof of publication consists of certified copies of the affidavits from the official state and parish journals attesting to publication. There is a fee of \$20 for providing proof of publication for a tract.

D. If an applicant wants to withdraw a nomination after the tract has been advertised for state wind lease, he shall submit a letter requesting withdrawal of the nomination to the State Mineral Board. No withdrawal shall be allowed unless approved by the State Mineral Board. If the State Mineral Board approves the request, the nomination fee payment shall not be refunded.

E. If a party wants to protest the State Mineral Board wind leasing a state tract, he shall submit a formal letter of protest to the State Mineral Board at least seven days prior to the meeting of the State Mineral Board to receive bids on the tract (generally the lease sale date). The letter of protest shall

reference the appropriate tract number, parish, and state mineral lease sale date, as well as set forth the source and nature of the title claimed, how and when acquired, and by what legal process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:263 (February 2008), repromulgated LR 41:1736 (September 2015).

§717. Submission of Bids on State Tract Offered for Wind Lease
[Formerly LAC 43:I.1017]

A. Interested, registered parties shall submit sealed bids on the entirety of a state tract advertised as offered for state wind lease to the Office of Mineral Resources in the form it requires by the bid submission deadline (generally no later than 12 noon CT on the Tuesday immediately prior to the Wednesday lease sale at which the tracts are offered unless otherwise noticed). Each bid shall be accompanied by any other documentation and information required.

B. Only those bidders who are registered prospective leaseholders with the Office of Mineral Resources as set forth under §707.B shall be allowed to bid on tracts for the purpose of obtaining a wind lease from the state of Louisiana.

C. A party interested in bidding on a state tract for wind lease shall prepare a bid packet that includes the items listed below. The bidder shall place all of the items required to be included in the bid packet in an envelope, completely seal the envelope, write the official tract number on the outside of the envelope, and notate on the outside of the envelope that "Sealed Bid for State Wind Lease is Enclosed." If a bidding party is submitting multiple bids then he may place the individual sealed bid packet envelopes into a larger envelope, completely seal the envelope, and notate on the outside of the envelope that "Sealed Bids for State Wind Lease are Enclosed."

1. An official bid form available from the Office of Mineral Resources. Provide one originally signed paper copies and no electronic copy.

2. A summary of experience that shall include, at a minimum, the number of years experience in the exploration, development and production of wind energy and project descriptions. Experience with wind energy projects involving government lands and water bottoms shall be so specified.

3. A proposed plan of operations that shall set forth the following:

a. a summary of the overall business plan of the proposed wind energy development including size of operation, development costs, marketing of the site, market prices, and status of acquiring a power purchase agreement;

b. a summary of the overall wind project including status of site control (progress with leasing other properties within the entire wind project boundaries), wind data reviews, and application process with the transmission provider, as well as a time frame for the project to be operational;

c. summary of the wind development (include plat) proposed on the state lands and water bottoms sought to be leased including layout of wind power and transmission facilities, proposed wind tower information (size, location, number), which towers will be affixed to existing platforms,

which towers will necessitate newly constructed platforms, turbine make, type, nameplate power production capacity, and selection criteria used, and supporting infrastructure;

d. the status and timeline of the major milestones in the wind project exploration, development, production, and decommissioning;

e. the name of the company that will operate the wind project and the linkage, if any, to the applicant;

f. a summary of the expected revenue and cash flow for the wind project on state lands and water bottoms, including a detailed list of assumptions;

g. the measures proposed to reduce risk to the state, including but not limited to, a summary of compliance with any and all wind energy standards established by the American National Standards Institute (ANSI), the American Wind Energy Association (AWEA), the International Electrotechnical Commission (IEC), and any other entity responsible for establishing wind industry consensus standards. Standards for wind energy development/operations include, but are not limited to, wind turbine safety and design, power performance, noise/acoustic measurement, mechanical load measurements, blade structural testing, power quality, and siting;

h. a summary of how the wind energy project will ensure the viability of the state's natural resources, provide a continuing energy source for the citizens and businesses of Louisiana, promote economic development through job retention and creation in the state of Louisiana, and promote a clean and lasting environment;

i. a summary of how the use of the state land and water bottoms for the exploration, development and production of wind energy will be coordinated with other users of the state lands and water bottoms.

4. A summary of the environmental issues including, but not limited to, avian and baseline noise levels, the environmental impact of the placement of wind turbines and other equipment necessary for the exploration, development and production of wind energy, and the steps proposed to minimize the environmental impact, along with any supporting environmental impact documentation.

5. A list of project participants who are or will be participating in the planning, predevelopment, construction, operation, maintenance, remediation, and/or decommission phases of the proposed project, and a brief description of their role. This list shall be supplemented for each new project participant.

6. A summary of project financing which shall include, at a minimum, identification of the sources of financing and a discussion of such financing.

7. A list of governmental entities including each federal, state, parish and local governmental entity that has jurisdiction in the nomination area and for each, the contact person name, title, office address, telephone and fax numbers, and email, as well as the type of legal authority, if any, acquired or to be acquired from the governmental entity.

8. If two or more parties are submitting a joint bid, each party shall submit a Designation of Principal State Wind Lessee and Operator Form with the joint bid.

D. The sealed bid packet may be hand-delivered or mailed to the Office of Mineral Resources. However, whether hand-delivered or mailed, the sealed bid packet

shall be physically in the hands of appropriate Office of Mineral Resources personnel by the bid submission deadline (generally no later than 12 p.m. CT on the Tuesday immediately prior to the Wednesday lease sale at which the tracts are offered unless otherwise noticed). A receipt is generated in the name of and provided to the party delivering the bid. Any bid received after the deadline shall not be accepted. Further, no bid, once submitted, shall be thereafter withdrawn or canceled.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:264 (February 2008), repromulgated LR 41:1738 (September 2015).

§719. Examination and Evaluation of Bids for State Wind Lease

[Formerly LAC 43:I.1019]

A. Sealed bids for state wind lease shall be publicly opened and read aloud on the date advertised for the public opening of bids (generally the lease sale date at which the tract is offered) in the LaBelle Room, also known as the Conservation and Mineral Resources Hearing Room, located on the First Floor of the LaSalle Building at 617 North Third Street, Baton Rouge, LA. The State Mineral Board shall defer action on the bids for state wind lease until at least the next regular board meeting, but no later than 100 days, pending examination and evaluation of the bids by its staff. The State Mineral Board staff shall examine and evaluate the bids to confirm compliance with legal, procedural and technical requirements, as well as with any current policies and practices, based on available data and analyses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:265 (February 2008), repromulgated LR 41:1739 (September 2015).

§721. Award of State Wind Lease

[Formerly LAC 43:I.1021]

A. At the next regular board meeting following conclusion of the staff's examination and evaluation of the bids for state wind lease, after the staff has technically briefed the board in executive session as to the merit of the bids, the State Mineral Board shall reconvene in open session at the lease sale (generally held the same day as the regular board meeting). The Office of Mineral Resources' designee shall publicly announce the staff's recommendations to the board as to which bids should be accepted and which bids should be rejected, providing the reasons for rejection. The State Mineral Board shall announce its state wind lease award decision at the lease sale.

B. Information as to bids on and awards of state wind leases shall be published in SONRIS, the Department of Natural Resources' Strategic Online Natural Resources Information System.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:265 (February 2008), repromulgated LR 41:1739 (September 2015).

§723. Issuance and Execution of State Wind Lease Contract

[Formerly LAC 43:I.1023]

A. The Office of Mineral Resources collects the entire dollar amount (bonus) and 10 percent administrative fee within 24 hours of state wind lease award, assigns a state wind lease number to each bid accepted by the State Mineral Board, prepares the state wind lease contract as awarded, and circulates the final contract of lease for execution, proper recordation in the appropriate parish public records, and timely return within 20 days for filing in the official state wind lease files.

B. Payment of the entire dollar amount (bonus) and 10 percent administrative fee shall be due within 24 hours of state wind lease award. Payment of both sums may be made in one payment and shall be made to the Office of Mineral Resources via certified funds or wire transfer and all proceeds shall be negotiated and transmitted for processing in accordance with law. The lease contract shall not be mailed out to the wind lessee until the entire dollar amount (bonus) and 10 percent administrative fee are received by the Office of Mineral Resources.

C. After the Office of Mineral Resources receives the entire dollar amount (bonus) and 10 percent administrative fee, personnel shall mail at least three original state wind lease contracts, properly executed by the State Mineral Board, to the state wind lessee per the bidder name and contact information provided in the official bid form via certified USPS mail return receipt requested.

D. Upon receipt of the lease packet via certified mail, the state wind lessee has 20 days from the date on the certified mail receipt or, if no date is affixed thereon, from the date the Office of Mineral Resources receives the certified mail receipt, to return one fully executed original lease contract and the recordation information from each parish wherein it is recorded to the Office of Mineral Resources. Failure to return one fully executed original lease contract and the recordation information from each parish wherein it is recorded to the Office of Mineral Resources within 20 days may result in forfeiture of the lease including the dollar amount (bonus) and 10 percent administrative fee. Further, failure to follow the notarization requirements of R.S. 35:12 shall cause the lease to be rejected.

E. A party may request proof that a particular state wind lease granted by the State Mineral Board was timely executed by using the official form available from the Office of Mineral Resources. Proof of timely execution of lease consists of a certificate issued by the Office of Mineral Resources certifying that the lease was received in the Office of Mineral Resources, duly executed by the lessee, within the allotted 20 day period. There is a fee of \$5 for providing proof of timely execution of lease.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:266 (February 2008), repromulgated LR 41:1739 (September 2015).

§725. Transfer of Interest in or Assignment of a State Wind Lease

[Formerly LAC 43:I.1025]

A. Prior to execution and recordation of a transfer of interest in or assignment of a state wind lease, a prospective transferee or assignee of a state wind lease shall schedule a pre-transfer meeting with and submit a transfer packet to the Office of Mineral Resources no later than the State Mineral Board regular meeting for the month prior to the State Mineral Board regular meeting at which the item is to appear on the State Mineral Board docket for approval.

B. The transfer or assignment shall be docketed for State Mineral Board approval. No transfer or assignment in relation to any state wind lease shall be valid unless approved by the State Mineral Board. Failure to obtain State Mineral Board approval of any transfer or assignment of a state wind lease prior to transfer or assignment shall subject the transferor or assignor and the transferee or assignee, jointly, severally and in solido, to liquidated damages of \$100 per day beginning on the first day following the execution of the transfer or assignment.

C. All parties to transfers or assignments in relation to any state wind lease shall be registered prospective leaseholders with the Office of Mineral Resources. Transfers or assignments shall not be granted to prospective leaseholders that are not currently registered with the Office of Mineral Resources as set forth under forth under §707.B.

D. The transfer packet shall contain the following items:

1. two original, unexecuted, unrecorded transfer or assignment instruments:

a. provide the marital status of the assignor if the assignor is an individual and, if applicable, the spouse's name and space for the spouse's signature to be affixed thereon;

b. designate the operator and the party who shall be the principal state wind lessee authorized to act on behalf of all co-lessees and attach proof of such agency;

c. after State Mineral Board approval, the transfer or assignment instrument must be executed by both assignor and assignee (and spouse(s), if appropriate), with each signature duly witnessed and a notarized witness acknowledgement provided for each, or the assignee (and spouse, if appropriate) shall execute an acceptance by assignee form, with the signature duly witnessed and notarized, and a copy attached to each of the transfer instruments;

2. a designation of principal state wind lessee and operator form completed by each prospective leaseholder;

3. a separate statement of conveyance—wind lease form completed for each state wind lease impacted by the transfer and reflect only the gross working interest in the lease existing before and after the conveyance (no net revenue interests are to be considered or reported);

4. a proposed plan of operations that includes all the items set forth in §717.C.3.a-i;

5. any environmental impact documentation supplementing and updating §711.C.8;

6. a list of project participants who are or will be participating in the planning, predevelopment, construction,

operation, maintenance, remediation, and/or decommission phases of the proposed project, and a brief description of their role. This list shall be supplemented for each new project participant;

7. a summary of project financing which shall include, at a minimum, identification of the sources of financing and a discussion of such financing;

8. a list of governmental entities including each federal, state, parish and local governmental entity that has jurisdiction in the nomination area and for each, the contact person name, title, office address, telephone and fax numbers, and email, as well as the type of legal authority, if any, acquired or to be acquired from the governmental entity;

9. if state wind lease operations have commenced, general liability insurance in a form acceptable to the State Mineral Board as set forth in §729.A.2 and financial security in a form acceptable to the State Mineral Board as set forth in §729.A.3;

10. a docket fee payment in the amount of \$100 made payable to the Office of Mineral Resources to cover the cost of preparing and docketing transfers or assignments of state wind leases. A personal or business check is acceptable;

11. any other information and documentation required by the Office of Mineral Resources.

E. After receiving State Mineral Board approval of the transfer or assignment, record the approved transfer instrument and the approval resolution in the appropriate parish(es) per the approval resolution and furnish the Office of Mineral Resources with the recordation information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:266 (February 2008), repromulgated LR 41:1740 (September 2015).

§727. Partial or Full Release of a State Wind Lease
[Formerly LAC 43:I.1027]

A. Upon expiration or termination of a state wind lease, in whole or in part, for any reason, the principle state wind lessee shall execute and record an appropriate instrument of release within 90 days of such expiration or termination in each parish wherein the leased premises are located and shall provide the State Mineral Board through the Office of Mineral Resources with a copy of the recorded instrument of release from each parish wherein it is recorded properly certified by the recorder for that parish. In the event the principle state wind lessee fails to comply, all the state wind lessees currently of record jointly, severally and in solido shall be subject to liquidated damages of \$100 per day beginning on the ninety-first day after expiration or termination, as well as reasonable attorney fees and costs incurred should suit be brought for lease cancellation.

B. The release instrument shall provide the state wind lease number and be signed by the principle state wind lessee, with the signature duly witnessed and notarized. Failure to follow the notarization requirements of R.S. 35:12 shall be grounds for the release instrument to be rejected.

C. If a party wants to release only a portion of the leased acreage, he shall contain the whole of the retained acreage, including the buffer acreage within the boundaries set forth in §729.C.1.a-c, within a single contiguous block of acreage. For a partial release only, the party shall also provide the following items.

1. A written property description, fully justified, using Microsoft Word. The first part shall describe and provide the amount of state owned acreage released. The second part shall describe and provide the amount of state owned acreage retained. Use X-Y Coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), starting with an X-Y point of beginning and using distance and bearings to each X-Y corner or turning point. Use calculations, closures and ties to existing state wind leases that comply with generally accepted surveying standards. Provide one original paper copy and one electronic copy as a Word .doc file named "released.doc" on the release diskette.

2. A plat that clearly delineates the boundaries of and sets forth the state owned acreage amount released and the state owned acreage amount retained. Use an 8 1/2 x 11 copy of the most recent edition of the 7 1/2 minute USGS Quadrangle Map (scale 1" = 2000' or 1" = 3000'; or the block system of 1" = 4000', if applicable). Use X-Y Coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), starting with an X-Y point of beginning and using distance and bearings to each X-Y corner or turning point. Use calculations, closures and ties to existing state wind leases that comply with generally accepted surveying standards. Provide one original paper copy and one electronic copy included as a .pdf file named "released.pdf" on the release diskette.

3. A .dxf file that contains only the boundary of the acreage portion to be released, named "released.dxf" and provided on the release diskette. This boundary shall be a single line with no additional lines, labels, text, or graphics, and shall be constructed of individual line segments between vertices. The X-Y coordinates in the .dxf file must exactly match those in the written property description and the plat.

4. A release diskette clearly labeled "State Wind Lease Release Diskette" that shall have the principal state wind lessee and project names affixed thereon and contain the written property description as a Word .doc file, the plat as a .pdf file, and the .dxf file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:267 (February 2008), repromulgated LR 41:1740 (September 2015).

§729. State Wind Lease Operations

[Formerly LAC 43:I.1029]

A. The state wind lessee and state wind lease operator shall schedule a pre-operations meeting with and submit an operations packet to the Office of Mineral Resources at least 30 days prior to commencement of construction. The operations packet shall contain the following items:

1. notice of beginning of wind lease operations form;
2. proof of general liability insurance for the leased premises in the amount of at least \$1,000,000 issued by an insurer to whom A.M. Best Company has given not less than an A rating, specifically covering all damages, and name as insured the state of Louisiana and its departments, agencies and boards:

- a. subsequent to the commencement of construction, an updated proof of general liability insurance is required to be submitted by January 31 of each year. Failure to submit updated proof of general liability insurance may cause the Office of Mineral Resources to levy

liquidated damages of \$100 per day until such proof is received;

3. financial security in a form acceptable to the State Mineral Board. The financial security amount for individual turbines shall be, at a minimum, \$150,000 per turbine for turbines in one location. Blanket financial security for lessees and operators with wind leases in more than one area shall be calculated at a minimum of \$150,000 per turbine divided by the number of different wind farm locations. Compliance with this financial security requirement shall be provided by any of the following or a combination thereof:

- a. a certificate of deposit issued in sole favor of the Louisiana Department of Natural Resources in a form prescribed by the board from a financial institution acceptable to the board; or

- b. a performance bond in sole favor of the Louisiana Department of Natural Resources in a form prescribed by the board issued by an appropriate institution authorized to do business in the state of Louisiana; or

- c. a letter of credit in sole favor of the Louisiana Department of Natural Resources in a form prescribed by the board issued by a financial institution acceptable to the board;

4. an updated plan of operations that includes all the items set forth in §717.C.3.a-I;

5. any updated environmental impact documentation supporting §711.D.8;

6. an updated list of project participants as set forth in §717.C.5;

7. any other information and documentation required by the Office of Mineral Resources.

B. At the expiration of the primary term, production of wind generated electric power shall be required to maintain the lease in force. If the lessee is producing wind generated electric power, the lease shall continue in force so long as production of wind generated electric power continues without lapse of more than 180 days. Any lapse in production of wind generated electric power greater than 180 days shall result in automatic termination of the lease.

C. On or before five years after the lessee commences the production of wind generated electric power on the lease, or five years from the end of the primary term, whichever is sooner (said date being the "Undeveloped Acreage Release Date"), the lessee shall release undeveloped acreage pursuant to the requirements of this Subpart, as well as those set forth in §727.

1. Lessee shall survey the exact locations of any physical improvements that it has made upon the property including, but not limited to, turbines, towers, controller boxes, foundations, guy wires, roads, overhead and underground electrical wires, communication lines, poles and cross members, and substations and transmission facilities, and shall further show on such survey the areas of land containing the improvements with the following boundaries:

- a. approximately 50 feet from the closest point on which a meteorological tower, road, guy wire, or transmission line is located;

- b. approximately 150 feet from the perimeter of any substation; and

- c. approximately 400 feet from the axis of horizontal rotation of any turbine.

2. Lessee shall contain the whole of the retained acreage, including the buffer acreage within the boundaries set forth in Subparagraphs 1.a-c, within a single contiguous block of acreage.

D. Any and all wind data collected during the primary term of the lease by the state wind lessee shall be released to public record at the end of the primary term.

E. The Office of Mineral Resources may require periodic reporting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:267 (February 2008), repromulgated LR 41:1741 (September 2015).

§731. State Wind Lease Electric Power Production Royalty Payment and Reporting
[Formerly LAC 43:I.1031]

A. A state wind lease shall contain a provision permitting the state, at its option, to take in kind all or any part of the portion due it as royalty of any wind generated electric power produced from the leased premises. Unless the state elects to exercise this in kind option, which option is expressly reserved by the state and which is to be exercised by written notice by the state to the state wind lessee ("lessee") at any time and from time to time while a state wind lease is in effect and either prior or subsequent to acceptance by the state of royalties other than in kind, it being understood that nothing contained in a state wind lease shall ever be interpreted as limiting or waiving this option, the lessee shall pay to the state as electric power production royalty an amount that shall be no less than the minimum amount set by the State Mineral Board of the lessee's gross revenues. For the purposes of a state wind lease, *gross revenues* shall mean and include:

1. all gross receipts of lessee from the sale of electricity generated by lessee on the leased premises; provided, however, that if electricity is sold to a subsidiary or affiliate of lessee, then, and only then, the gross receipts from the sale of electricity under such contract shall be calculated using a sale price of not less than the arithmetical average of the prices paid by any purchaser or purchasers (including lessee or any subsidiary or affiliate of lessee) for electricity produced in Louisiana during the calendar year immediately preceding the year in which such electricity production from the leased premises occurs; plus

2. the greater of the gross proceeds received by either lessee or any subsidiary or affiliate of lessee from the sale of any credits, credit certificates or similar items such as those for greenhouse gas reduction, or the generation of green power, renewable energy or alternative energy, created by any governmental authority and generated by wind energy development on the lease; but specifically excluding any and all federal production tax credits, investment tax credits and any other tax credits which are or will be generated by wind energy development on the lease; plus

3. the greater of gross proceeds or other cash benefits received by either lessee or any subsidiary or affiliate of lessee in connection with or under or derived from any agreement, compromise, settlement, judgment or arrangement for or relating to the sale, use or other disposition of electricity generated or capable of being generated from the lease; plus

4. anything of value received by the state wind lessee in return for electricity.

B. All royalties accruing under a state wind lease (including those paid in kind) shall be without deduction for the cost of producing, interconnecting, transporting and otherwise making electric production available for sale or use at the delivery side of the substation.

C. Prior to the first royalty payment, lessee shall complete a payor notification form available from the Office of Mineral Resources. If the payor attributable to a state wind lease changes between payment dates without notification to the Office of Mineral Resources of the change and without submission of the current mailing address, telephone number, and email address for the new payor prior to the next payment, the new payor shall be subject to liquidated damages of \$1,000. The State Mineral Board may waive all or any part of the liquidated damages based on a consideration of all factors bearing on the issue.

D. The first payment of royalty shall be made within 120 days following commencement of production of wind generated electric power from the leased premises. Thereafter, royalty shall be paid by the twenty-fifth of the second month following that in which wind generated electric power is produced. In the event any royalty payment is not correctly or timely made, lessee shall pay legal interest, until paid, on royalty owing under the terms of this lease commencing the date such royalty is due and payable, along with damages, attorney fees, and costs. The state may also seek dissolution of the lease.

E. A state wind lessee shall report royalty payments on the official royalty reporting form available from the Office of Mineral Resources. Payment shall accompany the official royalty reporting form. Payments equal to or less than \$9,999 may be made by personal or business check. Payments greater than \$9,999 shall be made by electronic wire transfer. In all cases, the payee shall be the Office of Mineral Resources.

F. A state wind lessee shall keep true, accurate and complete books, records, accounts, contracts and data sufficient to support and verify the calculation of all amounts due under the lease. The state or any representative of the state shall have the right at all reasonable times and upon the provision of reasonable notice, to inspect the books, accounts, contracts, records, and any other relevant data, in possession or control of lessee and pertaining to the production, transportation or sale of electricity produced from the lease premises, including, without limitation, statements, documents, records or other data, from third parties which verify price, value or quantity of electricity generated on the lease premises. Any such inspection and review shall take place at the office of lessee, unless another location is otherwise agreed to by the state and lessee.

G. Should a state wind lessee contest royalty payment or any form of payment under a state wind lease, including requests for recoupment of any alleged overpayment of royalty, or present any claim, dispute or question pertaining to the terms, conditions, obligations, and duties expressed or implied in a state wind lease, the Office of Mineral Resources may collect a fee of \$35 per hour for each hour or portion thereof spent in verification of any such contest, claim, dispute, or question.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:268 (February 2008), repromulgated LR 41:1742 (September 2015).

§733. State Wind Lease Decommissioning
[Formerly LAC 43:I.1033]

A. Definitions to be used in this Section:

Decommissioning—ending wind energy operations and returning the lease to a condition that meets the requirements of the Minerals Management Service, U.S. Department of the Interior, as required by R.S. 41:1732.C, as well as the requirements of the Louisiana Department of Natural Resources, State Mineral Board and Office of Mineral Resources, and the requirements of any other agencies that have jurisdiction over decommissioning activities.

Facility—any installation used for wind energy activities that is permanently or temporarily attached to state lands or water bottoms. Facilities may include obstructions.

Obstructions—structures, equipment or objects that were used in wind energy operations that, if left in place, would hinder other users of the state lands or water bottoms. Obstructions may include, but are not limited to, wind turbines, towers, pads, platforms, templates, pilings, shell mounds, overhead and underground electrical transmission and communications lines, electric transformers, energy storage facilities, telecommunications equipment, power generation facilities, roads, meteorological towers and wind measurement equipment, control buildings, maintenance yards, transmission towers, wires, cables, substations, and related facilities and equipment.

B. Lessees and owners of operating rights are jointly and severally responsible for meeting decommissioning obligations for facilities and obstructions on leases, as the obligations accrue and until each obligation is met. In this Section, the terms *you* or *I* refer to lessees and owners of operating rights, as to facilities installed under the authority of a lease.

C. You accrue decommissioning obligations when you install a facility, create an obstruction to other users of the state lands and water bottoms, are or become a lessee or the owner of operating rights of a lease on which there is a facility or an obstruction, or re-enter a facility or an obstruction that was previously abandoned.

D. When your facilities are no longer useful for operations, you shall get approval from the Office of Mineral Resources before decommissioning facilities and then permanently remove all facilities and obstructions created by your lease operations in a manner that is safe, does not unreasonably interfere with other users of the state lands or water bottoms, and does not cause undue or serious harm or damage to the human, wildlife, aquatic, or coastal environment.

E. You shall submit decommissioning applications and receive approval and submit subsequent reports according to the table in this Subpart.

Decommissioning Applications and Reports Table		
Decommissioning Applications and Reports	When to Submit	Instructions
1. Final removal application for a facility	Before removing a facility	Include information required under Subpart G
2. Post-removal report for a facility	Within 30 days after you remove a facility	Include information required under Subpart I
3. Site clearance report for a facility	Within 30 days after you complete site clearance verification activities	Include information required under Subpart N

F. You shall remove all facilities within one year after the lease terminates unless you receive approval to maintain a facility to conduct other activities. Before you may remove a facility, you shall submit a final removal application to the Office of Mineral Resources for approval and include the information listed in Subsection G. You shall remove a facility according to the approved application. You shall notify the Office of Mineral Resources at least 48 hours before you begin the removal operations.

G. You shall submit a final removal application to remove a facility to the Office of Mineral Resources for approval. Provide one paper copy and one electronic copy of the final removal application. The final removal application shall include the following, as applicable:

1. applicant identification including lease operator, address, contact person and telephone number, and shore base;
2. facility identification including facility name/ID number, location (lease, area, X-Y coordinates based on the Louisiana Coordinate System of 1927, block name and number), year installed, proposed date of removal (month/year), and water depth;
3. description of the facility you are removing including configuration (attach a photograph or a diagram), size, brief description of soil composition and condition, the maximum removal lift weight and estimated number of main lifts to remove the facility, and any other pertinent information;
4. a description, including anchor pattern, of the vessel(s) you will use to remove any facility from state water bottoms;
5. identification of the purpose, including lease expiration date and reason for removing the facility;
6. a description of the removal method, including a brief description of the method you will use. If you are using explosives, the type of explosives, number and sizes of charges, whether you are using a single shot or multiple shots, if multiple shots, the sequence and timing of detonations, whether you are using a bulk or shaped charge, depth of detonation below ground level or mud line (as applicable), whether you are placing the explosives inside or outside of the facility, and a statement whether or not you will use transducers to measure the pressure and impulse of the detonations;

7. if removing a facility from state water bottoms, whether you will use divers or acoustic devices to conduct a pre-removal survey to detect the presence of aquatic life and a description of the proposed detection method;

8. your plans for transportation and disposal (including as an artificial reef) or salvage of the removed facility;

9. if available, the results of any recent biological surveys conducted in the vicinity of the structure and recent observations of wildlife or aquatic life at the facility site;

10. your plans to protect archaeological and sensitive biological features during removal operations, including a brief assessment of the environmental impacts of the removal operations and procedures and mitigation measures you will take to minimize such impacts;

11. your plans to return and restore the state lands or water bottoms to a condition as nearly equivalent to that which existed before said operations were conducted and/or facility was constructed;

12. if removing a facility from state water bottoms, a statement whether or not you will use divers to survey the area after removal to determine any effects on aquatic life.

H. Unless the Office of Mineral Resources approves an alternate depth under Paragraph 2 of this Subpart, you shall remove all facilities on state water bottoms to at least 15' below mud line and you shall remove all facilities on state lands to at least 2' below plow depth. The Office of Mineral Resources may approve an alternate removal depth if:

1. the remaining facility or part thereof would not become an obstruction to other users of the state lands and water bottoms, and geotechnical and other information you provide demonstrate that erosional processes capable of exposing the obstructions are not expected; or

2. if removing a facility from state water bottoms, you determine, and the Office of Mineral Resources concurs, that you must use divers and the seafloor sediment stability poses safety concerns.

I. Within 30 days after you remove a facility, you shall submit a post-removal report to the Office of Mineral Resources that includes the following:

1. a summary of the removal operation including the date it was completed;

2. a description of any mitigation measures you took; and

3. a. statement signed by your authorized representative that certifies that the types and amount of explosives you used in removing the facility were consistent with those set forth in the approved final removal application.

J. The Office of Mineral Resources may grant a departure from the requirement to remove a facility by approving partial facility removal or toppling in place for conversion to an artificial reef or other use if you meet the following conditions:

1. the structure becomes part of a state artificial reef program, and the responsible state agency acquires a permit from the U.S. Army Corps of Engineers and accepts title and liability for the facility; and

2. you satisfy any U.S. Coast Guard (USCG) navigational requirements for the facility.

K. Within 60 days after you remove a facility from state water bottoms, you shall verify that a site is clear of obstructions by using one of the following methods.

1. For a facility site in water depths less than 300 feet, you shall drag a trawl over the site.

2. For a facility site in water depths 300 feet or more, you shall drag a trawl over the site, scan across the site using sonar equipment or use another method approved by the Office of Mineral Resources if the particular site conditions warrant.

L. If you drag a trawl across the site, you shall comply with the following.

1. Drag the trawl in a grid-like pattern across a 1,320 foot radius circle centered on the location of the facility.

2. Trawl 100 percent of the limits, described in Subparagraph 1 above, in two directions.

3. Mark the area to be cleared as a hazard to navigation according to USCG requirements until you complete the site clearance procedures.

4. Use a trawling vessel equipped with a calibrated navigational positioning system capable of providing position accuracy of +/-30 feet.

5. Use a trawling net that is representative of those used in the commercial fishing industry (one that has a net strength equal or greater than that provided by No. 18 twine).

6. Ensure that you trawl no closer than 300 feet from a shipwreck, and 500 feet from a sensitive biological feature.

7. If you trawl near an active pipeline, you must meet the requirements in the following table.

For-	You Must Trawl-	And You Must-
1. Buried active pipelines		First contact the pipeline owner or operator to determine the condition of the pipeline before trawling over the buried pipeline.
2. Unburied active pipelines that are 8 inches in diameter or larger	no closer than 100 feet to the either side of the pipeline	Trawl parallel to the pipeline. Do not trawl across the pipeline.
3. Unburied smaller diameter active pipelines in the trawl area that have obstructions (e.g., pipeline valves) present	no closer than 100 feet to either side of the pipeline	Trawl parallel to the pipeline. Do not trawl across.
4. Unburied active pipelines in the trawl area that are smaller than 8 inches in diameter and have no obstructions present.	parallel to the pipeline	

8. Ensure that any trawling contractor you may use has no corporate or other financial ties to you and has a valid commercial trawling license for both the vessel and its captain.

M. If you do not trawl a state water bottom site, you can verify that the site is clear of obstructions by using any of the methods shown in the following table.

If You Use-	You Must-	And You Must-
1. Sonar	Cover 100 percent of the appropriate grid area.	Use a sonar signal with a frequency of at least 500 kHz.
2. A diver	Ensure that the diver visually inspects 100 percent of the appropriate grid area.	Ensure that the diver uses a search pattern of concentric circles or parallel lines spaced no more than 10 feet apart.
3. An ROV (remotely operated vehicle)	Ensure that the ROV camera records videotape over 100 percent of the appropriate grid area.	Ensure that the ROV uses a pattern of concentric circles or parallel lines spaced no more than 10 feet apart.

N. Within 60 days after you remove a facility from state lands other than water bottoms, you shall verify that you have returned and restored the state lands to a condition as nearly equivalent to that which existed before said operations were conducted and/or facility was constructed.

O. You shall submit a site clearance report to the Office of Mineral Resources within 30 days after you complete the verification activities. The site clearance report shall include the following:

1. a letter signed by an authorized company official certifying that the facility site area is cleared of all obstructions and that a company representative witnessed the verification activities;
2. a letter signed by an authorized official of the company that performed the verification work for you certifying that they cleared the facility site area of all obstructions;
3. the date the verification work was performed and if applicable, the vessel used;
4. the extent of the area surveyed;
5. the survey method used;
6. the results of the survey, including a list of any debris removed or, if applicable, a statement from the trawling contractor that no objects were recovered; and
7. a post-trawling job plot or map showing the trawled area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Mineral Resources, LR 34:269 (February 2008), repromulgated LR 41:1743 (September 2015).

Chapter 9. Leasing State Owned Lands and Water Bottoms for the Exploration, Development and Production of an Alternative Energy Source

Editor's Note: Pursuant to Act 196 of the 2009 Regular Session, the name of the State Mineral Board has been changed to State Mineral and Energy Board.

§901. Authority [Formerly LAC 43:I.1101]

A. These rules and regulations are promulgated by the state Mineral and Energy Board (Board) in consultation with the Department of Transportation and Development (DOTD) pursuant to the Administrative Procedure Act as authorized by R.S. 41:1734.

B. A Port Authority's denial of the issuance of a state alternative energy source lease (AESL) shall be adjudicated in accordance with the Administrative Procedure Act as set forth at 49:991 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:125 (January 2012), repromulgated LR 41:1745 (September 2015).

§902. Purpose [Formerly LAC 43:I.1102]

A. These rules and regulations are promulgated for the following purposes:

1. to implement the provisions and intent of the legislature as set forth in Chapter 14-A of Title 41 of the Louisiana Revised Statutes of 1950;
2. to establish procedures for the issuance and administration of leases for alternative energy source production on state lands and water bottoms;
3. to notify the lessee and third parties of obligations as required in this Chapter;
4. to ensure that alternative energy source activities conducted on state lands or water bottoms for energy related purposes are implemented in a safe and environmentally sound manner, in conformance with state laws, federal laws and other applicable laws and regulations, and the terms of the Alternative Energy Source Lease;
5. to institute reasonable fees for services performed by the Department of Natural Resources (DNR).

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:125 (January 2012), repromulgated LR 41:1745 (September 2015).

§903. Wind Energy and Geothermal Energy Alternative Energy Sources [Formerly LAC 43:I.1103]

A. The Alternative Energy Source Rules as set forth in Chapter 9, except as provided in §912 and §913, do not apply to wind energy or geothermal alternative energy sources.

B. An applicant for a wind energy lease must comply with the requirements as set forth in R.S. 41:1731 et seq.

C. An applicant for a geothermal energy lease must comply with the requirements as set forth in R.S. 30:800 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:126 (January 2012), repromulgated LR 41:1745 (September 2015).

§904. Cash Bonus and Fees for Alternative Energy Source Leases [Formerly LAC 43:I.1104]

A. The state shall collect a cash bonus for all AESLs. In addition to the cash bonus, the board, through the Office of Mineral Resources (OMR), shall collect an administrative fee for such leasing in the amount of 10 percent of the total cash bonus paid. Such payments shall be due within 24 hours of award of the state Alternative Energy Lease.

B. The state may collect additional payments for an Alternative Energy Source Lease if authorized by statute.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 34:260 (February 2008), LR 38:126 (January 2012), repromulgated LR 41:1745 (September 2015).

Subchapter A. General Provision

§907. Lease Authorization

[Formerly LAC 43:I.1107]

A. Except as otherwise authorized by law, it will be unlawful for any person or business entity to explore for, drill, develop, construct, operate, or maintain any facility to produce, transport, or support the generation of electricity or other energy product derived from an alternative energy source on any part of state owned lands and water bottoms except under and in accordance with the terms of a lease issued by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:126 (January 2012), repromulgated LR 41:1746 (September 2015).

§908. Acronyms

[Formerly LAC 43:I.1108]

A. For the purposes of this Chapter, unless the terms are defined in a different Chapter or Subpart, the following acronyms shall apply.

1. OMR—the Office of Mineral Resources serving as staff to the state Mineral and Energy Board.
2. AESL—the state Alternative Energy Source Lease.
3. DNR—the Department of Natural Resources.
4. OSL—the Office of State Lands.
5. DWF—the Department of Wildlife and Fisheries and/or the Wildlife and Fisheries Commission.
6. Board—the State Mineral and Energy Board.
7. FERC—the Federal Energy Regulatory Commission as established pursuant to 42 U.S.C. §7171.
8. AESP—a project requiring an AESL.
9. DOTD—the Department of Transportation and Development.

AUTHORITY NOTE: Promulgated in accordance with R.S. 41:1734.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:126 (January 2012), repromulgated LR 41:1746 (September 2015).

§909. Definitions

[Formerly LAC 43:I.1109]

A. For the purposes of this Chapter, unless the terms are defined in a different Chapter or Subpart, the following terms shall have the following meanings. Terms defined in a different Chapter or Section shall have the meaning as defined in that Chapter, Subpart, or Section:

Alternative Energy Source—an energy source other than oil, gas, and other liquid, solid, or gaseous minerals. Including, but not limited to, wind energy, geothermal energy, solar energy, and hydrokinetic energy. It shall not include the cultivation or harvesting of biomass fuels or the use of state land or water bottoms for facilities which utilize biomass fuel to produce energy.

Archaeological Resource—any material remains of human life or activities that are at least 50 years of age and that are of archaeological interest (i.e., capable of providing scientific or humanistic understanding of past human behavior, cultural adaptation, or related topics through the application of scientific or scholarly techniques, such as controlled observation, contextual measurement, controlled collection, analysis, interpretation, and explanation).

Best Available and Safest Technology—the best available and safest technologies recognized within the respective industry, or by government, feasible wherever failure of equipment would have a significant effect on safety, health, or the environment.

Best Management Practices—practices recognized within the respective industry, or by government, as one of the best for achieving the desired output while reducing undesirable outcomes.

Commercial Activities—any and all activities associated with the generation, storage, or transmission of electricity or any other energy product from a project requiring an AESL (hereinafter referred to as “AESP”) on state lands or water bottoms, when such electricity or other energy product is intended for distribution, sale, or other commercial use, including, but not limited to, initial site characterization and assessment, facility construction, and project decommissioning.

Decommissioning—the removal of alternative energy source facilities or any other activity associated with the return of the lease site to a condition pursuant to the requirements of Subpart E of this Chapter. Excluded from this provision are technology-testing activities.

Interstate Commerce—any commercial transaction involving more than one state or the movement of goods with respect to the electric power and energy across state boundaries.

Intrastate Commerce—any commercial transaction or movement of goods with respect to the electric power and energy wholly within the state.

Interstate Transmission—the generation of electric power used for the transmission of electric energy in interstate commerce.

Intrastate Transmission—the generation of electric power used for the transmission of electric energy in intrastate commerce.

Lease Applicant—a person or business entity who is formally seeking an AESL in which the port; harbor and terminal district; or port, harbor, and terminal district has not granted prior written approval for the development of an alternative energy source.

Legal Area—state lands or water bottoms subject to a compromise agreement or legal adjudication.

Lessee—the holder of an AESL granted by the board, including any approved sub-lessee, assignee, or successor, or any person or business entity authorized by the holder of the lease or operator to conduct activities on the lease.

Levee District—defined pursuant to the definition set forth in R.S. 38:281(6).

Marine—the physical, atmospheric, and biological components, conditions, and factors that interactively determine the productivity, state, condition, and quality of the marine ecosystem. These include the waters of the high seas, the contiguous zone, transitional and intertidal areas, salt marshes, and wetlands within the coastal zone and in the state.

Operator—the individual, business, or other legal entity having control or management of activities on the leased acreage, including, but not limited to, the lessee or a third party designated by the lessee.

Political Subdivision—defined pursuant to the definition set forth in R.S. 42:1102(17).

Port Authority—the governing authority of any port; harbor and terminal district; or port, harbor, and terminal district.

Revenue—a bonus or other similar payment owed and/or paid by the lessee to the lessor as required under the lease. It does not include administrative fees such as those assessed for cost recovery, civil penalties, and forfeiture of financial assurance.

Riverine—relating to or situated on a river or riverbank.

Secretary—the Secretary of the Department of Natural Resources (DNR) or an official authorized to act on the Secretary's behalf.

Significant Archaeological Resource—an archaeological resource that is eligible to be listed in the National Register of Historic Places, as defined in 36 CFR 60.4 or its successor.

Site Assessment Activity—preliminary activity(ies) performed by the lessee for the purpose of characterizing a site on state lands or water bottoms, in preparation of the installation of facilities. Such activities may include, but are not limited to, resource assessment surveys (e.g., meteorological and oceanographic) or technology testing.

State—the state of Louisiana, its agencies, departments, successors, predecessors, legal representatives, officers, agents, employees, and any other party or entity authorized to act on its behalf.

State Agency—defined pursuant to the definition set forth in R.S. 30:151.

Vessel—defined pursuant to the definition set forth in USC Title 1, Section 3.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:127 (January 2012), repromulgated LR 41:1746 (September 2015).

§910. Rights Granted Pursuant to an Alternative Energy Source Lease
[Formerly LAC 43:I.1110]

A. A lease issued under this Section grants the lessee the right, subject to obtaining the necessary approvals, including, but not limited to, those required under the Federal Energy Regulatory Commission (FERC) hydrokinetic energy licensing process, and complying with all provisions of this Section, to occupy, and install and operate facilities on a designated portion of state owned lands or water bottoms for the purpose of conducting:

1. commercial activities related to the production of energy from an alternative energy source;
2. other limited activities that support, result from, or relate to the production of energy from an alternative energy source.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:127 (January 2012), repromulgated LR 41:1747 (September 2015).

§911. Impediment to Louisiana's Waterways
[Formerly LAC 43:I.1111]

A. The AESP shall not unreasonably adversely impact, impede, obstruct, or interfere with transportation infrastructures, the navigability of any waterway, or the use of the waterway by other users, nor shall it unreasonably interfere with maritime commerce or the recreational use of the waterway.

B. The AESP shall be designed to have minimum impact on the chemical, physical, biological integrity, and safety of the waterway.

C. The DOTD shall review the AESP to identify any unreasonable adverse impacts the AESL will have on transportation and transportation infrastructures and submit its findings to the board prior to the opening of the AESL bid. Failure by DOTD to submit its findings to the board shall indicate to the board that the AESP has no adverse impact on transportation and transportation infrastructures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:127 (January 2012), repromulgated LR 41:1747 (September 2015).

§912. Port Authority Approval Required
[Formerly LAC 43:I.1112]

A. No AESL which affects the following state owned lands and/or water bottoms shall be advertised or granted without prior written approval of a Port Authority:

1. lands held in title by a Port Authority or held by lease or servitude by a Port Authority;
2. public navigable waters that flow through any lands within the jurisdiction of a Port Authority. Approval pursuant to this Section shall not be unreasonably withheld unless the lease is detrimental to the needs of commerce and navigation.

B. No Port Authority shall receive compensation for its approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:127 (January 2012), repromulgated LR 41:1747 (September 2015).

§913. Decision of Port Authority
[Formerly LAC 43:I.1113]

A. After the decision of the Port Authority has been made to either grant or deny the applicant's lease request, the board, through OMR, shall notify the AESL applicant of the Port Authority's decision via certified U. S. Postal Service First Class Mail, return receipt requested.

B. If the AESL request is denied by the Port Authority, the applicant shall have 60 days from receipt of the board notice to request an administrative hearing with the Division of Administrative Law, pursuant to Chapter 13-B, Title 49 of the Louisiana Revised Statutes of 1950 and Chapter 9.

C. The Port Authority shall contract with the Division of Administrative Law to conduct the administrative hearing.

D. The Port Authority which did not grant prior written approval for the proposed AESL shall have the burden of proof at the administrative hearing that the proposed AESL is detrimental to the needs of commerce and navigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1747 (September 2015).

§914. Federal Energy Regulatory Commission
[Formerly LAC 43:I.1114]

A. No AESL for hydrokinetic energy development shall be granted which is inconsistent with the terms of a preliminary permit, license, exemption, or other authorization issued by FERC pursuant to its authority under the Federal Power Act, 16 U.S.C. 791a, et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1748 (September 2015).

§915. Federal and State Laws
[Formerly LAC 43:I.1115]

A. The lessee, including successors and assigns, is subject to all applicable laws, statutes, rules, or regulations, whether state or federal, which deal with the subject matter of the lease during the term the AESL is in force and effect, whether in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1748 (September 2015).

§916. Alternative Energy Source Project Design Safeguards
[Formerly LAC 43:I.1116]

A. The lessee or operator shall design its AESP and conduct all activities in a manner that ensures safety and which will not cause undue harm or damage to any structures and/or natural resources, physical, atmospheric, and biological components, including, but not limited to, those owned by the state, Port Authority, Political Subdivision, or Levee District.

B. The lessee and/or operator shall compile, retain, and make available to the board, DOTD, affected Port Authority, and Levee District, or its authorized representative, within the time specified by the board, any data or information related to the site assessment, design, or operations of the alternative energy source.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1748 (September 2015).

§917. Rights Granted and/or Denied by an Alternative Energy Source Lease
[Formerly LAC 43:I.1117]

A. No AESL shall include any rights to explore, drill, mine, develop, or produce for native oil, gas, or other liquid or gaseous hydrocarbons.

B. No usage of state lands or water bottoms for the development of a specific alternative energy source shall unreasonably interfere, as determined by the board, with the rights of oil and gas or other forms of an AESL.

C. The AESL shall not inhibit any activity, right, obligation or duty inherent to an oil and gas lease granted by the board.

D. The AESL shall not prevent the letting of leases of state owned lands or water bottoms for the purpose of developing its natural resources.

E. Notwithstanding any language of the AESL to the contrary, the rights granted exclusively to the alternative energy source lessee shall be subject to the surface usage for coastal restoration, reclamation or conservation projects promulgated, funded or effected through DNR and its divisions, whether solely or in conjunction with other state, local or federal governmental agencies or with private individuals or entities. The alternative energy source lessee, in the exercise of its exclusive rights granted pursuant to the AESL, shall utilize the best available technology so as to minimize interference with any surface usage entailed in the development, construction, and maintenance of coastal restoration, reclamation, and conservation projects.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1748 (September 2015).

§918. Environmental Safeguards
[Formerly LAC 43:I.1118]

A. The lessee shall use the best management practice, the highest degree of care, the best available and safest technology and all proper safeguards required to prevent land or water pollution resulting from the construction, transportation, and operations of an alternative energy source.

B. The lessee shall use all means available to recapture escaped pollutants and shall be solely responsible for any and all damages to aquatic or marine or riverine life, wildlife, birds, or any public or private property resulting from the lessee's operations.

C. The lessee shall not discharge trash or debris into state waterways.

D. The lessee shall report all unpermitted discharges of pollutants in violation of federal or state laws to the Department of Environmental Quality, the board, through OMR, and any other appropriate agency, within the time required by federal, state or local laws, but not more than 24 hours from the occurrence, whichever is earlier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:128 (January 2012), repromulgated LR 41:1748 (September 2015).

§919. Adherence to Laws and Regulations
[Formerly LAC 43:I.1119]

A. The lessee shall comply with all applicable environmental laws and regulations and any other federal, state, or local law, regulation, standard, or resolution passed by the board, which may be applicable to alternative energy source activities. The board may require lessee to obtain any environmental or other permits or licenses required before applying for an AESL.

B. The board shall have the option of terminating the AESL agreement should the lessee fail to abide by such rules, regulations and resolutions; provided, however, the board shall give the lessee written notice of any such violation and 10 days in which to correct such violation, in which event, should said violation not be corrected, the

board, without further notice, may terminate the AESL agreement.

C. With respect to violations of rules, regulations, or resolutions of the federal government or its agencies, when the state is notified of a violation by the lessee, the board, through OMR, shall notify the lessee and may suspend operations under the AESL agreement while allowing the lessee a reasonable set time to resolve the issues with the appropriate federal authority, and, if resolution is not obtained in a reasonable time, terminate the AESL agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:129 (January 2012), repromulgated LR 41:1748 (September 2015).

§920. Alternative Energy Source Lease Size

[Formerly LAC 43:I.1120]

A. The board shall determine the size of each lease based on the acreage required to accommodate the anticipated activities. The AESL shall include the minimum area that will allow the lessee sufficient space to develop the AESP and manage activities in a manner that is consistent with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:129 (January 2012), repromulgated LR 41:1749 (September 2015).

§921. Construction and Operations Plan (COP)

[Formerly LAC 43:I.1121]

A. In accordance with the requirements of this Chapter, all AESL applicants must submit to the board, or its authorized representative, a Construction and Operations Plan (COP). The COP shall describe the proposed construction, operations, and conceptual decommissioning plans under the AESL, and shall:

1. describe all planned facilities the lessee will construct and use for the AESP, including onshore and support facilities;

2. describe all proposed activities, including the proposed construction activities, commercial operations, and conceptual decommissioning plans for all planned facilities, including onshore and support facilities;

3. certify that the AESP conforms to all applicable laws, implementing regulations, lease provisions, and stipulations or conditions;

4. certify that the AESP does not cause undue harm or damage to natural resources; life (including human and wildlife); property; the marine, coastal, riverine, or human environment; or sites, structures, or objects of historical or archaeological significance;

5. Certify that the AESP does not unreasonably adversely impact, interfere or impede the navigability of waterways nor interfere with the dredging or maintenance of a waterway for navigation purposes.

6. certify that the AESP does not unreasonably adversely impact, interfere or impede other users of a waterway;

7. certify and demonstrate as needed that the AESP uses the best management practices and the best available and safest technology;

8. provide a detailed explanation showing how the AESP will not damage state owned lands and water bottoms and port authority facilities or property and public or private property such as bridges, docks, and piers;

9. provide a detailed explanation of the waterway marking system that the lessee shall install to aid navigation by marking obstructions in the navigable waters of the state.

B. The board, through OMR, shall review the COP submitted by the lease applicant to determine if the COP contains all the required information. Additional information may be requested if it is determined that the information provided is not complete. If the lease applicant fails to provide the requested information, the AESL application may be denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:129 (January 2012), repromulgated LR 41:1749 (September 2015).

§922. Navigation Aid

[Formerly LAC 43:I.1122]

A. The alternative energy source lessee shall construct, maintain, and operate at its own expense such lights and signals as may be directed by either FERC or the secretary of the department in which the Coast Guard is operating, and as may be required by the Port Authority or DOTD. The Port Authority or DOTD may only impose stricter navigation aid standards than those required by FERC or the Coast Guard.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:129 (January 2012), repromulgated LR 41:1749 (September 2015).

§923. State Indemnity

[Formerly LAC 43:I.1123]

A. The alternative energy source lessee shall defend, indemnify and hold harmless the state (and its designated officials) and its political subdivisions against any expenses, losses, costs, damages, claims (including, without limitation, claims for loss of life or illness to persons, or for damage to property), actions, proceedings, or liabilities of any kind, character or type arising out of or in any way connected to the AESL agreement as allowed by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:129 (January 2012), repromulgated LR 41:1749 (September 2015).

§924. Easements and Rights-of-Way

[Formerly LAC 43:I.1124]

A. The lessee shall be responsible for securing authorization, easements, rights-of-way, leases or permission necessary to obtain access to state lands or water bottoms. The AESL agreement shall not provide access to any waterway.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1749 (September 2015).

§925. Notification Requirements
[Formerly LAC 43:I.1125]

A. The lessee shall notify the board in writing within five business days after the lessee files any action alleging insolvency or bankruptcy.

B. The lessee shall notify the board, through OMR, in writing within 30 days of any merger, name change, or change of address and contact information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1750 (September 2015).

Subchapter B. Lease Administration

§929. Overview of an Alternative Energy Source Lease Acquisition Process
[Formerly LAC 43:I.1129]

A. Leases for the exploration, development and/or production of an alternative energy source on state lands or water bottoms under Chapter 14-A of Title 41 of the Louisiana Revised Statutes of 1950 shall be acquired from the board, through OMR, through a public bid process as set forth in this Chapter or as designated in a separate alternative energy source Subpart. The general steps in the AESL acquisition process are as follows:

1. registration;
2. pre-nomination requirements;
3. nomination of state lands or water bottoms for an AESL;
4. examination and evaluation of the nomination;
5. advertisement of state tract(s) offered for an AESL, including a request for bids and/or comments;
6. submission of bids on a state tract for an AESL;
7. examination and evaluation of bids for an AESL;
8. award of an AESL;
9. issuance and execution of an AESL.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1750 (September 2015).

§930. Registration
[Formerly LAC 43:I.1130]

A. All persons or business entities applying for an AESL shall register with the board, through OMR, prior to submitting an application and, thereafter, renew their registration annually by January 31.

B. Registration consists of submitting a completed official Prospective Leaseholder Registration Form (obtainable from the board, through OMR,) and appropriate documentation from the Louisiana Secretary of State's Office to the board, through OMR, as follows.

1. Individual/Sole Proprietorship—no additional documents required.
2. Corporation—Louisiana Secretary of State "Detailed Record" webpage indicating good standing status.
3. Limited Liability Company—Louisiana Secretary of State "Detailed Record" webpage indicating good standing status.

4. Partnership—Louisiana Secretary of State "Detailed Record" webpage indicating active status.

C. If a current alternative energy source lessee fails to renew its annual registration, the board may levy liquidated damages of \$100 per day until the unregistered lessee is properly registered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1750 (September 2015).

§931. Pre-Nomination Requirements
[Formerly LAC 43:I.1131]

A. Prior to any nomination of state lands or water bottoms for an AESL, the nominating party shall:

1. conduct research prior to nomination to determine and confirm that the state land or water bottoms are available for the AESL and are claimed by the state;
2. provide a copy of the compromise instrument(s), or judgment(s) that establish(es) the state ownership interest, if the state lands or water bottoms include a legal area;
3. certify that the user(s) of any active or non-released land use agreement granted by the state on nominated land or water bottoms has been notified of the proposed AESL;
4. provide an affidavit, in authentic form, attesting that:

a. there are no encumbrances, including, but not limited to, current state leases, areas nominated for lease, or pipeline rights-of-way on state lands or water bottoms.;

b. any and all users of state lands or water bottoms to be nominated for an AESL have been notified of the proposed AESL. The affidavit shall include:

- i. the official name and/or number of the governing agreement;
- ii. the official name of the state entity that granted the governing agreement.

5. it is the responsibility of the alternative energy source applicant to consult and coordinate with the Port Authority with jurisdiction over lands or navigable water bottoms located within, or immediately adjacent to, the proposed AESL tract. An AESL cannot be issued without the written approval of the Port Authority with jurisdiction within the AESL area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1750 (September 2015).

§932. Nomination of State Lands and Water Bottoms for an Alternative Energy Source Lease
[Formerly LAC 43:I.1132]

A. Interested, registered parties shall nominate state lands and water bottoms for an AESL by submitting a proposal (hereinafter referred to as a "nomination") by application to the board, through OMR, in the appropriate form required. Each nomination shall include the following:

1. an official letter of application;
2. any title documentation obtained by the nominating party pursuant to §931.A;
3. a written property description of the nominated acreage including the following:

a. the gross acreage amount of state lands or water bottoms, inclusive of any DWF property that may be contained within the nomination area;

b. the net acreage amount of state lands or water bottoms, exclusive of any DWF property that may be contained within the nomination area;

c. the net acreage amount of any DWF property that may be contained within the nomination area;

d. provide the following property description for state lands and water bottoms:

i. use bearing, distance and X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), to accurately and clearly describe the nominated acreage. Determine whether the acreage to be nominated falls in the North Zone or the South Zone of the Louisiana Coordinate System of 1927 and provide this information in the nomination package. A single nomination may contain acreage that falls partially in the North Zone and partially in the South Zone. However, the nominated acreage shall be allocated to the zone wherein the majority of the acreage falls and use that zone's coordinates (see R.S. 50:1);

4. a plat of the nominated acreage using the most recent background imagery and using X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable). Each plat shall include:

a. an outline of the nominated acreage with a designated point of beginning and corners using X-Y coordinates that exactly match the X-Y coordinates for the point of beginning and corners provided in the written property description, clearly labeled therein;

b. an outline of the state lands and/or water bottoms included within the nomination area, clearly labeled along with the amount of acreage contained therein;

c. an outline of any DWF property, school indemnity lands, tax adjudicated lands, vacant state lands, White Lake, or legal areas, included within the nomination area, clearly labeled along with the acreage amount contained in each;

d. an outline of each active or non-released land use agreement granted by the state, including, but not limited to, an AESL, state mineral lease, state operating agreement, state exclusive geophysical agreement, state non-exclusive seismic permit, state right-of-way, and/or state surface/subsurface agreement, as well as any nomination tract approved for advertisement or advertised as offered for a state mineral lease, state operating agreement, or state exclusive geophysical agreement abutting, adjacent to, intersecting, and partially/wholly enclosed in the nomination area, clearly labeled with its official number along with the acreage amount contained therein.

e. all water bodies, clearly labeled;

f. all section, township and range information;

g. An outline of all Port Authority property in the nomination area with jurisdictional boundaries clearly delineated.

5. A summary of all environmental issues, including the potential environmental impacts resulting from the construction, operation, and placement of the alternative energy source and other facilities and equipment necessary for the exploration, development and production of an alternative energy source, and the steps proposed to

minimize and mitigate the environmental impact, along with any supporting environmental impact documentation.

6. A list of governmental entities, including each federal, state, parish or local governmental entity, having jurisdiction in the nomination area, and for each, the contact person's name, title, office address, telephone and fax numbers, and email address, as well as the type of legal authority, if any, acquired or to be acquired from the governmental entity. Included in this list shall be all port authority districts in the nomination area with complete contact information.

7. A copy of the preliminary permit, license, exemption, or other authorization issued by FERC pursuant to its authority under the Federal Power Act, 16 U.S.C. 791a, et seq., if required.

8. A summary of the overall specified AESP, including status of site control (progress with leasing and/or permitting other properties within the entire AESP boundaries) and application process with the transmission provider, as well as a time frame for the project to become operational.

9. A summary of the alternative energy source development proposed on the state lands or water bottoms sought to be leased, including a plat, the layout of the specified alternative energy source power and transmission facilities, proposed alternative energy source equipment information (size, location, number, type and depth of installation, turbine make, and nameplate power production capacity), placement information of equipment, whether the alternative energy source will be affixed to existing platforms or state owned structures or, if there will be a necessity to construct new platforms, selection criteria used, and supporting infrastructure.

10. The status and timeline of the major milestones in the AESP development, production, and decommissioning.

11. The measures proposed to reduce risk to the state, including, but not limited to, a summary of compliance with any and all standards established by state, national and international agencies, institutes, commissions or associations and any other entity responsible for establishing the alternative energy source industry standards. Standards for the alternative energy source development/operations include, but are not limited to, turbine safety and design, power performance, noise/acoustic measurement, mechanical load measurements, blade structural testing, power quality, and siting.

12. A summary of how the use of the state lands or water bottoms for the development and production of the alternative energy source will be coordinated with other users of the state lands or water bottoms, including the operation of ports, harbors, or terminal districts, shipping and recreational interests, dredging operations, and navigation safety.

13. A summary of contingency plans and emergency shut-down procedures to be followed, including the circumstances to initiate such procedures, in the event of danger or damage to life, water craft or facilities as a result of collision, dredging, anchorage, search and rescue operations, or unforeseen events.

14. A summary of the procedure for installation, recovery and repair of damaged turbines and equipment with

minimal impact to navigation, shipping and recreational interests.

15. A summary of all study results, including copies of the complete final study reports, and all study data acquired by the applicant in a format agreeable to OMR, for all studies conducted by the applicant, for the area described in the lease application.

16. Any other information and documentation required by the board through OMR.

B. Each of the above items shall be submitted in original paper form. Additionally, a CD-ROM or DVD (hereinafter referred to as the "Nomination Disk") clearly labeled "AESL Nomination Disk" shall be submitted. Each Nomination Disk shall be affixed with the applicant and project names thereon and shall contain an electronic version of Item 3.d. above as a Word .doc file and Item 4. above as a .pdf file. Each Nomination Disk shall also contain a .dxf file which shall contain only the boundary of the nominated acreage, consisting of a single line, no additional lines, labels, text, or graphics, and shall be constructed of individual line segments between vertices. The X-Y coordinates in the .dxf file must exactly match those in the written property description and the plat.

C. The nominating party of an AESL shall observe the following restrictions:

1. Only bearing, distance and X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), shall be used and coordinates shall accurately and clearly describe the nominated acreage. If a single nomination contains acreage that is split between the North and South Zones, the nominated acreage shall be allocated to the zone containing the majority of the acreage pursuant to R.S. 50:1.

2. No more than 2,500 acres of state lands or water bottoms may be nominated in a single nomination.

D. Any other additional information required pursuant to §1121 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:130 (January 2012), repromulgated LR 41:1750 (September 2015).

§933. Examination and Evaluation of Nomination for an Alternative Energy Source Lease [Formerly LAC 43:I.1133]

A. Upon verification by the board, through OMR, that the AESL nomination complies with legal, procedural and technical requirements, as well as with any current policies and practices:

1. The board, through OMR, shall evaluate the AESL nomination. If the nomination is acceptable, OMR shall:

a. place the AESL nomination tract on the board Nomination and Tract Evaluation Committee Agenda for the next regular scheduled board meeting;

b. recommend to the board, pursuant to §1134, that a public bid process be conducted to advertise the nomination.

2. The board, through OMR, shall remove the acreage from commerce for the purpose of an AESL until the final outcome of the nomination is determined.

3. The board, through OMR, shall make available, after board approval, via the OMR website at

www.dnr.louisiana.gov, the nomination application as outlined in §932.

4. The Office of State Lands (OSL), Department of Wildlife and Fisheries (DWF), and DOTD shall:

a. review the proposed location of the AESL;

b. certify to the board if there are other leases of any kind at the proposed lease location;

c. if there is an existing lease, the respective agency(ies) shall provide copies to the board of the lease(s).

5. The board, through OMR, shall transmit the nomination package and all other lease certifications to the secretary of DNR for evaluation.

B. An applicant may withdraw a nomination during the examination and evaluation process if notification is transmitted prior to the tract being officially advertised for an AESL by submitting a written request to OMR, Attention: Leasing Section, P.O. Box 2827, Baton Rouge, LA 70821-2827.

C. An applicant may not withdraw after the tract has been advertised without approval of the board. To obtain approval, the applicant shall submit a letter requesting withdrawal of the nomination to the board. If the board approves the request, the nomination fee payment shall not be refunded.

D. The decision of the Port Authority, when required in accordance with §912 shall be submitted in written form. The Port Authority shall have 60 calendar days from the date the board approves the nomination to submit to the board, through OMR, a written decision to either grant or deny the AESL application. Failure of the Port Authority to submit a decision to the board, through OMR, within a specified time limit shall be considered a denial of the AESL application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:132 (January 2012), repromulgated LR 41:1752 (September 2015).

§934. Advertisement of a State Tract Offered for an Alternative Energy Source Lease and Request for Bids

[Formerly LAC 43:I.1134]

A. The board, through OMR, shall publish an advertisement of the state tract offered for an AESL and request for bids in the official journal of the state and official journal(s) of the parish(es) where the land(s) is/are located, and, at its discretion, no less than 60 and no more than 120 days prior to the date for the public opening of bids. The advertisement shall contain the following, which shall constitute judicial advertisement and legal notice pursuant to Chapter 5 of Title 43 of the Louisiana Revised Statutes of 1950:

1. a legal description of the nominated acreage;

2. the official tract number of the nominated acreage;

3. the gross and net amount of state lands or water bottoms nominated;

4. the date, time and place where the sealed bids will be received and publicly opened. Once a bid is submitted, it may not be withdrawn or cancelled. The board does not obligate itself to accept any bid. Bid acceptance or rejection is at the sole discretion of the board which reserves the right to reject any and all bids or to grant an AESL on any portion of state lands or water bottom tracts advertised and to withdraw the remainder of the tract.

B. All state AESLs shall be executed upon the terms and conditions provided in the current official state AESL form with any attached rider(s).

C. Notwithstanding any provisions to the contrary in any state AESL awarded or in any rider attached thereto, the lease awarded shall be granted and accepted without any warranty of title and without any recourse against the Lessor whatsoever, either expressed or implied. Further, Lessor shall not be required to return any payments received under the state AESL awarded or be otherwise responsible to the state alternative energy source lessee therefore.

D. Some tracts available for AESL may be situated in the Louisiana Coastal Zone as defined in R.S. 49:214 et seq., and may be subject to guidelines and regulations promulgated by DNR, Office of Coastal Management, for operations in the Louisiana Coastal Zone.

E. Prior to commencing construction, each state alternative energy source lessee and state AESL operator shall have a general liability insurance policy in a form acceptable to the board as set forth in Subpart D of this Chapter.

F. Prior to commencing construction, each state alternative energy source lessee and state AESL operator shall provide financial security in a form acceptable to the board as set forth in Subpart D of this Chapter.

G. Lessor excepts and reserves the full use of the leased premises and all rights with respect to surface and subsurface for any and all purposes except for those granted to the state alternative energy source lessee, including the use of the leased premises for the exploration, production and development of oil, gas and other minerals by the lessor, its mineral lessees, grantees or permittees. Co-users of the leased premises shall agree to coordinate plans and cooperate on activities to minimize interference with other operations to the extent possible.

H. To protest the board leasing of a state tract for an AESL, the protesting party shall submit a formal letter of protest to the board at least seven days prior to the scheduled board meeting to consider the AESL on the tract (generally, the lease sale date). The letter of protest shall reference the appropriate tract number, parish, and board lease sale date, as well as set forth the source and nature of the title claimed, how and when acquired, and by what legal process.

I. A party may request proof that a tract was advertised in the official state and parish journals using the official Request for Proof of Publication Form published by OMR. Proof of publication consists of certified copies of the affidavits from the official state and parish journals attesting to publication. There is a fee of \$40 for providing proof of publication for a tract.

J. Within 20 days of the advertisement of the state tract, any person or entity may submit written comments to the board, through OMR, at the following address: Department of Natural Resources, Office of Mineral Resources, Attn: Leasing Section, P.O. Box 2827, Baton Rouge, LA 70821-2827.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:132 (January 2012), repromulgated LR 41:1752 (September 2015).

§935. Submission of Bids on Tracts Offered for an Alternative Energy Source Lease [Formerly LAC 43:I.1135]

A. Interested registered parties shall submit sealed bids on the entirety of the state tract nominated and advertised as offered for an AESL to the board, through OMR, in the form it requires by the bid submission deadline (no later than 12 p.m. Central Time on the Tuesday immediately prior to the Wednesday board lease sale at which the tracts are offered, unless otherwise noticed). Each bid shall be accompanied by any other documentation and/or information required.

B. Only those bidders who are registered prospective leaseholders with OMR as set forth under §930 of this Chapter shall be allowed to bid on tracts for the purpose of obtaining an AESL from the state.

C. A party interested in bidding on a state tract for an AESL shall prepare a bid package that includes the items listed below. The bidder shall place all of the items required to be included in the bid package in an envelope, completely seal the envelope, write the official tract number on the outside of the envelope, and notate the following on the outside of the envelope: "Sealed Bid for State AESL is Enclosed". This envelope should include:

1. an official bid form available from OMR. Provide one original signed paper copy only;

2. a summary of experience including, at a minimum, the number of years of the bidding party's experience in the development and production of the specified alternative energy source and project descriptions. Experience with the specific AESP involving government lands and water bottoms shall be specified;

3. the proposed bid package shall set forth the following:

a. a summary of the overall business plan of the proposed alternative energy source development, including size of operation, development costs, marketing of the project, market prices, and status of a power purchase agreement;

b. a summary of the overall specified AESP, including status of site control (progress with leasing and/or permitting other properties within the entire AESP boundaries) and application process with the transmission provider, as well as a time frame for the project to become operational;

c. a summary of the alternative energy source development proposed on the state lands or water bottoms sought to be leased, including a plat, the layout of the specified alternative energy source power and transmission facilities, proposed alternative energy source equipment information (size, location, number, type and depth of installation, turbine make, and nameplate power production capacity), placement information of equipment, and whether the alternative energy source will be affixed to existing platforms or state owned structures or will there be a necessity to construct new platforms, selection criteria used, and supporting infrastructure;

d. the status and timeline of the major milestones in the AESP development, production, and decommissioning;

e. the name of the company that will operate the AESP and its relationship, if any, to the applicant;

f. a summary of the expected revenue and cash flow for the AESP on state lands or water bottoms, including a detailed list of assumptions;

g. the measures proposed to reduce risk to the state, including, but not limited to, a summary of compliance with any and all standards established by state, national and international agencies, institutes, commissions or associations and any other entity responsible for establishing the alternative energy source industry standards. Standards for the alternative energy source development/operations include, but are not limited to, turbine safety and design, power performance, noise/acoustic measurement, mechanical load measurements, blade structural testing, power quality, and siting;

h. a summary of how the AESP will ensure the viability of the state's natural resources, including, but not limited to, fish, wildlife and botanical resources, provide a continuing energy source for the citizens and businesses of Louisiana, promote economic development through job retention and creation in the state, and promote a clean and lasting environment;

i. a summary of how the use of state lands or water bottoms for the development and production of the alternative energy source will be coordinated with other users of state lands or water bottoms, including the operation of ports, harbors, or terminal districts, shipping and recreational interests, dredging operations, and navigation safety;

j. a summary of contingency plans and emergency shut down procedures to be followed, including the circumstances to initiate such procedures, in the event of danger or damage to life, water craft or facilities as a result of collision, dredging, anchorage, search and rescue operations, or unforeseen events;

k. a summary of the procedure for installation, recovery and repair of damaged turbines and equipment with minimal impact to navigation, shipping and recreational interests;

l. any other additional information required pursuant to §921 of this Chapter;

4. a comprehensive summary of all environmental issues including, but not limited to, the environmental impact resulting from the construction, placement, operation and removal of the alternative energy source's facilities and equipment necessary for the development and production of the alternative energy source, and the steps proposed to minimize the environmental impact, along with any supporting environmental impact documentation.;

5. a list of project participants who are or will be participating in the planning, development, construction, operation, maintenance, remediation, and/or decommission phases of the proposed project, and a brief description of each participant's role;

6. a summary of project financing which shall include, at a minimum, identification of the sources of financing and a discussion of financing;

7. a list of governmental entities, including each federal, state, parish and local governmental entity having jurisdiction in the nomination area, including the name of the contact person, his/her title, office address, telephone and fax numbers, and email address, as well as the type of legal

authority, if any, acquired or to be acquired from the governmental entity;

8. a summary of all study results, including copies of the complete final study reports and all study data acquired by the applicant, in a format agreeable to OMR, for all studies conducted by the applicant, for the area described in the lease application;

9. a summary detailing the project's impact and mitigation required to protect the historical and archaeological resources of the area.

D. The applicant shall deliver the sealed bid package to the board, through OMR, by either hand-delivery or traceable delivery service. The sealed bid package must be physically in the possession of appropriate OMR personnel by the bid submission deadline (generally no later than 12 p.m. Central Time on the Tuesday immediately prior to the Wednesday board lease sale at which the tracts are offered unless otherwise noticed).

E. Once a bid is submitted, it may not be withdrawn or cancelled. The board is not obligated to accept a bid. Bid acceptance or rejection is at the sole discretion of the board who reserves the right to reject any and all bids or to grant an AESL on any portion of the state tract advertised and to withdraw the remainder of the tract.

F. When two or more parties submit a joint bid, the parties shall designate the undivided percent interest of each party on the official bid form. The interests, so designated, shall be stipulated in any lease that may be awarded. Failure to designate the undivided percent interest of each joint bidder shall result in the board assigning equal interests to each bidder.

G. When two or more parties submit a joint bid, the parties shall designate on the official bid form, as well as on a separate form, the name of the principal AESL lessee, who shall be authorized to act on behalf of all co-lessees, including, but not limited to, the authority to release. The principal AESL lessee shall be stipulated in any lease that may be awarded.

H. A bid for an AESL shall exclude all rights not specifically granted in any AESL subsequently awarded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:1333 (January 2012), repromulgated LR 41:1753 (September 2015).

§936. Protest of an Alternative Energy Source Lease [Formerly LAC 43:I.1136]

A. If a party wants to protest the issuance of an AESL for a state tract, the party shall submit a formal letter of protest to the board at least seven days prior to the board's scheduled meeting to consider the AESL on the tract (generally, the lease sale date). The letter of protest shall reference the appropriate tract number, parish, and board lease sale date, as well as set forth the source and nature of the title claimed, how and when acquired, and by what legal process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:134 (January 2012), repromulgated LR 41:1754 (September 2015).

§937. Examination and Evaluation of Bids for an Alternative Energy Source Lease
[Formerly LAC 43:I.1137]

A. Sealed bids for a state AESL shall be publicly opened and read aloud on the date advertised for the public opening of bids (generally, the lease sale date at which the tract is offered) in the LaBelle Room, also known as the Conservation and Mineral Resources Hearing Room, located on the first floor of the LaSalle Building at 617 North Third Street, Baton Rouge, LA. The board shall defer action on the bids for the AESL until completion of the pending examination and evaluation of the bids by its staff, but no more than 120 calendar days after the opening of the bid. The board staff shall examine and evaluate the bids to confirm compliance with legal, procedural and technical requirements, as well as with any current policies and practices, based on available data and analyses.

B. If examination of the successful bid acreage amount reveals that there is more or less state acreage than the amount bid on, without exceeding the boundaries advertised, the dollar amount (bonus) shall be adjusted accordingly.

C. The board has the authority to accept or reject any bid.

D. The cash bonus and the administrative fee paid shall be negotiated and transmitted for processing in accordance with law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:134 (January 2012), repromulgated LR 41:1755 (September 2015).

§938. Award of an Alternative Energy Source Lease
[Formerly LAC 43:I.1138]

A. At the next regular board meeting following conclusion of the staff's examination and evaluation of the bids for an AESL, after the staff has technically briefed the board in executive session as to the merit of the bids and the approval of the COP, the board shall reconvene in open session at the lease sale. The OMR designee shall publicly announce the staff's recommendations to the board as to which bids should be accepted and which bids should be rejected, and providing the reasons for rejection. The board shall announce its AESL award decision at the lease sale.

B. Information, including bids, all required authorizations and approvals, and award of any AESL shall be published in the DNR Strategic Online Natural Resources Information System ("SONRIS").

C. The cash bonus and administrative fee, as required pursuant to §904, shall be due within 24 hours of the award of the AESL. Payments shall be made payable to the "Office of Mineral Resources" via certified funds, bank money order, cashier's check, bank wire, or Automated Clearing House (ACH) transfer. Failure to submit payments within 24 hours of the award of the AESL shall be deemed forfeiture by the applicant of the AESL.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:135 (January 2012), repromulgated LR 41:1755 (September 2015).

§939. Issuance and Execution of an Alternative Energy Source Lease
[Formerly LAC 43:I.1139]

A. OMR shall assign an AESL number to each lease awarded by the board, prepare the AESL as awarded, and mail no less than three original copies, properly executed by the board, to the alternative energy source lessee, via certified USPS mail, return receipt requested.

B. Upon receipt of the lease package via certified mail, the alternative energy source lessee will have 20 days from the date on the certified mail receipt or, if no date is affixed thereon, from the date the board, through OMR, receives the certified mail receipt, to return to the board, through OMR, one fully executed original lease contract and the recordation information from each parish wherein it is recorded. Failure to return one fully executed original lease contract and the recordation information from each parish wherein the lease is recorded to the board, through OMR, within 20 days may result in forfeiture of the AESL, including the dollar amount (bonus) and 10 percent administrative fee. Failure to follow the notarization requirements of R.S. 35:12 shall cause the lease to be rejected.

C. Any party may request proof that a particular AESL granted by the board was timely executed by using the official form available from OMR. Proof of timely execution of lease consists of a certificate issued by the board, through OMR, certifying that the lease was received by the board, through OMR, duly executed by the lessee, within the allotted 20 day period. There is a fee of \$5 for providing proof of timely execution of a lease.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:135 (January 2012), repromulgated LR 41:1755 (September 2015).

§940. Alternative Energy Source Lease Operations
[Formerly LAC 43:I.1140]

A. An AESL on state lands or water bottoms shall have a maximum initial term of five years and continue thereafter, as long as the alternative energy source operations are being conducted without interruption and electric power is being generated and used in significant quantities for the commercial transmission of electric energy and applicable fees are paid to the board, through OMR, in a timely manner.

B. All AESLs shall be executed upon the terms and conditions provided in the current official AESL with any attached rider(s).

C. Notwithstanding any provisions to the contrary in any AESL awarded or in any rider attached thereto, the lease awarded shall be granted and accepted without any warranty of title and without any recourse against the Lessor whatsoever, either expressed or implied. Further, Lessor shall not be required to return any payments received under the AESL awarded or be otherwise responsible to the lessee.

D. Lessor accepts and reserves the full use of the leased premises and all rights with respect to its surface and subsurface for any and all purposes except for those granted to the lessee, including the use of the leased premises for the exploration, production and development of oil, gas and other minerals by the Lessor, its mineral lessees, grantees or

permittees. Co-users of the leased premises shall agree to coordinate plans and cooperate on activities to minimize interference with other operations to the extent possible.

E. Prior to commencing construction, each lessee and AESL operator shall obtain a general liability insurance policy in a form acceptable to the board as set forth in §954 of this Chapter.

F. Prior to commencing construction, each lessee and AESL operator shall provide financial security in a form acceptable to the board as set forth in §953 of this Chapter.

G. Lessee hereby agrees that in exercising the rights granted under the AESL, it will comply with and be subject to all current applicable laws and regulations, including, but not limited to, environmental laws, ports and waterways laws, energy laws, and those validly adopted or issued, by the U.S. and its agencies, by the state of Louisiana and its agencies, and by any applicable local or parish government. Lessee further agrees that it will comply with all minimum water quality standards validly adopted by governmental authorities with respect to pollution, noxious chemicals, and waste being introduced into affected water areas.

H. Any contract entered into for the lease of state lands for any purpose shall require that access by the public to public waterways through the state lands covered by the lease shall be maintained and preserved for the public by the lessee. This provision shall not prohibit the secretary of the state agency having control over the property from restricting access to public waterways if the secretary determines that a danger to the public welfare exists. This provision shall not apply in cases involving title disputes.

I. The alternative energy source lessee operator shall schedule a pre-operations meeting with and submit an operations package to the board, through OMR, at least 30 days prior to commencement of construction. The operation package shall contain the following additional items:

1. notice of beginning of AESL operations;
2. proof of financial assurance as set forth in Subpart D of this Chapter;
3. an updated list of project participants;
4. any other information or documentation required by the board, through OMR.

J. At the expiration of the primary term, production of alternative energy source electric power shall be required to maintain the lease in force. If the lessee is producing alternative energy source generated electric power, the lease shall continue in force as long as production of generated electric power continues without lapse of more than 180 days, unless the suspension is due to a suspension order. Any lapse in production of generated electric power greater than 180 days may, at the board's discretion, result in the termination of the lease.

K. Lessee shall survey the exact locations of any physical improvements that it has made upon the property including, but not limited to, turbines and mounting structures, controller boxes, foundations, roads, overhead and underground electrical wires, communication lines, poles and cross members, and substations and transmission facilities, and shall further show the areas of land containing the improvements on the survey.

L. Any and all alternative energy source data collected during the term of the lease by the alternative energy source

lessee shall be provided to the board, through OMR, every six months. All information maps, plots, and other data provided to the board, through OMR, shall be deemed public record except where the record is designated as confidential by law. Any record determined to be confidential shall not be released to any agency or entity absent a valid court order from a court of competent jurisdiction.

M. Periodic reporting may be required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:135 (January 2012), repromulgated LR 41:1755 (September 2015).

§941. Transfer of Interest in or Assignment of an Alternative Energy Source Lease [Formerly LAC 43:I.1141]

A. Prior to execution and recordation of a transfer of interest in or assignment of an AESL, a prospective transferee or assignee of an AESL shall schedule a pre-transfer meeting with and submit a transfer package to the board, through OMR, no later than the board's regular meeting for the month prior to the board's regular meeting at which the item is to appear on the board's docket for approval.

B. No transfer or assignment in relation to any AESL shall be valid unless approved by the board prior to the transfer or assignment. Failure to obtain board approval of any transfer or assignment of an AESL prior to transfer or assignment shall subject the transferor or assignor and the transferee or assignee, jointly, severally and in solido, to liquidated damages of \$100 per day, beginning on the first day following the execution of the transfer or assignment.

C. Transfers or assignments shall not be granted to prospective leaseholders that are not currently registered with OMR as set forth under §930 of this Chapter.

D. The transfer package shall contain the following items:

1. an official letter from FERC approving the transfer of the federal energy license, if required;
2. two original, unexecuted, unrecorded transfer or assignment instruments designating the operator and the principal alternative energy source lessee authorized to act on behalf of all co-lessees with proof of designation attached.;
3. a Designation of Principal State Alternative Energy Source Lessee and Operator Form completed by each prospective leaseholder;
4. a separate Statement of Conveyance of Alternative Energy Source Lease Form completed for each AESL impacted by the transfer. Each form shall reflect only the gross working interest in the lease existing before and after the conveyance (no net revenue interests shall be considered or reported);

5. a proposed plan of operations that includes all items set forth in §935.C.3.a.-l. of this Chapter;

6. any environmental impact documentation supplementing and updating §932.A.5 of this Chapter;

7. a list of project participants who are or will be participating in the planning, development, construction, operation, maintenance, remediation, and/or decommission phases of the proposed AESP, and a brief description of each project participant's role;

8. a summary of project financing which shall include, at a minimum, identification of the sources of financing and a discussion of the financing;

9. a list of governmental entities, including each federal, state, parish and local governmental entity that has jurisdiction in the leased area and for each, the contact person's name, title, office address, telephone and fax numbers, and email address, as well as the type of legal authority, if any, acquired or to be acquired from the governmental entity;

10. if AESL operations have commenced, proof of general liability insurance held by the transferee/assignee in a form acceptable to the board as set forth in §954 of this Chapter and proof of financial assurance from the transferee/assignee in a form acceptable to the board as set forth in §953 of this Chapter;

11. a docket fee in the amount of \$100 made payable to the "Office of Mineral Resources" to cover the cost of preparing and docketing transfers or assignments of an AESL. A personal or business check shall be acceptable;

12. any other information and documentation required.

E. An assignment or other transfer made by lessee which has been approved by the board does not relieve the original lessee, or any of its successors or assigns, of any and all obligations, duties, or responsibilities incurred under the terms of the AESL.

F. No assignment or transfer of an AESL shall be valid unless a provision has been made by the assignor or transferor and assignee or transferee to have the financial security and insurance set forth in this Chapter maintained in full force and effect following the assignment or other transfer into the authority of the assignee. Written evidence of the maintenance of the required financial security and insurance shall be presented together with the assignment or other transfer at the same time as submitted for the board's approval. The same shall hold true for each and every successive assignment or transfer of an interest in the AESL.

G. Upon board approval of the transfer or assignment, the transferor/assignor or transferee/assignee shall record the approved transfer instrument and the approval resolution in the appropriate parish(es) per the approval resolution and shall furnish the board, through OMR, with an original certified copy of the recorded instrument from the respective clerk of court office(s).

H. Upon board approval, the transfer or assignment instrument shall be executed, in authentic form, by both transferor and transferee/assignor and assignee [and spouse(s), if appropriate]. As an alternative, the transferee/assignee [and spouse(s), if appropriate] may execute an acceptance by assignee form, executed in authentic form, with a copy attached to each of the transfer instruments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:136 (January 2012), repromulgated LR 41:1756 (September 2015).

§942. Partial or Full Release of an Alternative Energy Source Lease **[Formerly LAC 43:I.1142]**

A. Upon expiration or termination of an AESL, in whole or in part, for any reason, the principle alternative energy source lessee shall execute and record an appropriate

instrument of release within 90 days of expiration or termination in each parish wherein the leased premises are located and shall provide the board, through OMR, with a copy of the recorded instrument of release from each parish wherein it is recorded properly certified by the recorder for that parish. In the event the principle alternative energy source lessee fails to comply, all other active joint-lessees shall be jointly and solidarily liable for liquidated damages in the amount of \$100 per day commencing on day 91 after expiration or termination. The lessee(s) shall also be responsible for reasonable attorney fees and costs incurred should litigation be required for AESL cancellation.

B. The release instrument shall contain the AESL number and shall be signed by the principle alternative energy source lessee, with the signature duly witnessed and notarized. Failure to follow the notarization requirements of R.S. 35:12 shall be grounds for rejection of the release instrument.

C. Should a lessee wish to release only a portion of the leased acreage, the lessee shall contain the whole of the retained acreage within a single contiguous block of acreage.

1. For a partial release only, the lessee shall also provide the following items:

a. a written property description, fully justified, using Microsoft Word. The first part shall describe and provide the amount of state owned acreage released. The second part shall describe and provide the amount of state owned acreage retained. X-Y coordinates shall be based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable), shall be used, starting with an X-Y point of beginning and using distance and bearings to each X-Y corner or turning point. Calculations, closures and ties to existing AESLs that comply with generally accepted surveying standards shall be used;

b. a plat that clearly delineates the boundaries of and sets forth the state owned acreage amount released and the state owned acreage amount retained. An 8½" x 11" paper copy of the most recent edition of the 7½ minute USGS Quadrangle Map (scale 1" = 2000' or 1" = 3000'; or the block system of 1" = 4000', if applicable) shall be used. X-Y coordinates based on the Louisiana Coordinate System of 1927, North or South Zone (as applicable) shall be used, starting with an X-Y point of beginning and using distance and bearings to each X-Y corner or turning point. Calculations, closures and ties to existing AESLs that comply with generally accepted surveying standards shall be used;

2. Each of the above items shall be submitted in original paper form. Additionally, a CD-ROM or DVD ("AESL Release Disk") clearly labeled "AESL Release Disk" shall be submitted. Each AESL Release Disk shall be affixed with the lessee and project names thereon and shall contain an electronic version of Item C.1.a. above as a Word.doc file and Item C.1.b. above as a .pdf file. Each Nomination Disk shall also contain a .dxf file which shall contain only the boundary of the acreage portion to be released and that portion to be retained, each consisting of a single line, no additional lines, labels, text, or graphics, and shall be constructed of individual line segments between vertices. The X-Y coordinates in the .dxf file must exactly match those in the written property description and the plat.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:137 (January 2012), repromulgated LR 41:1757 (September 2015).

**Subchapter C. Alternative Energy Source Lease
Suspension or Cancellation**

**§945. Partial or Full Suspension of an Alternative Energy Source Lease
[Formerly LAC 43:I.1145]**

A. The board, or an authorized representative of the board, may order a suspension after notice and opportunity for a hearing of the AESL under the following circumstances:

1. when necessary to comply with judicial decrees prohibiting some or all activities under the AESL;
2. when continued activities pose an imminent threat of serious or irreparable harm or damage to natural resources, life (including human and wildlife), property, the marine, coastal, riverine, or human environment, or sites, structures, or objects of historical or archaeological significance;
3. when the alternative energy source operations adversely impact, impede, obstruct, or interfere with the navigability of any waterway, the use of the waterway by other users, or interfere with maritime commerce or the recreational use of the waterway;
4. lessee or its operator fails to comply with an applicable law, regulation, order, resolution, or provision of the AESL.

B. If the board, or its authorized representative, orders a suspension under Paragraph A.2. or A.3. of this Subpart, and the lessee wishes to resume activities, the board, or its authorized representative, may require the lessee to conduct a site-specific study to evaluate the cause of the harm, the potential damage, and/or the available mitigation measures.

1. The lessee shall be responsible for payment of the site-specific study.
2. The lessee shall furnish one paper copy and one electronic copy of the site-specific study and results to the Board or its authorized representative.
3. The board, or its authorized representative, will make the results available to other interested parties and to the public.
4. The board, or its authorized representative, will use the results of the site-specific study and any other information that becomes available:

- a. to determine if the suspension order should be lifted;
- b. to determine any actions that the lessee must take to mitigate or avoid any damage to natural resources, life (including human and wildlife), property, the marine, coastal, riverine, or human environment, or sites, structures, or objects of historical or archaeological significance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:137 (January 2012), repromulgated LR 41:1758 (September 2015).

**§946. Suspension Order
[Formerly LAC 43:I.1146]**

A. The board, or its authorized representative, shall issue a suspension order in accordance with the following procedures:

1. The suspension order may be in oral form or in writing.

2. The board, or its authorized representative, will send the lessee a written suspension order as soon as practicable after issuing an oral suspension order.

3. The written order shall explain the reasons for issuance and describe the effect of the suspension order on the AESL and any associated activities. The board, or its authorized representative, may authorize certain activities or require the removal of certain equipment at the lessee's expense during the period of the suspension, as set forth in the suspension order.

4. The lessee shall have the right to have a hearing at the next scheduled board meeting to petition for the revocation of the suspension order.

B. A suspension order shall last for the period specified in the order. If the board determines that the circumstances responsible for initiation of the suspension order cannot be resolved within a reasonable time period, the board may initiate cancellation of the AESL.

C. A suspension order shall not extend the terms of the AESL for a time period equal to the period of time the lessee is prohibited from conducting activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:138 (January 2012), repromulgated LR 41:1758 (September 2015).

**§947. Equipment Removal Order or Cancellation of an Alternative Energy Source Lease
[Formerly LAC 43:I.1147]**

A. The board shall cancel any AESL issued under this Part upon proof that the AESL was obtained by fraud or misrepresentation, and after notice and opportunity to be heard has been afforded to the lessee.

B. The board may cancel an AESL issued under this Part if the board determines, after notice and opportunity for a hearing, that the lessee has failed to comply with any applicable provision of these rules, any order of the board, or any term, condition or stipulation contained in the AESL, and that the failure to comply continued for 30 days (or other period the board specifies) after lessee received notice from the board or its authorized representative of non-compliance.

C. The board may cancel the AESL and/or require the lessee to suspend its operations and remove all equipment at lessee's cost from the state lands or water bottoms at any time if the state determines, after the lessee has been given notice and a reasonable opportunity to be heard, that:

1. continued operations under the AESL will cause serious harm or damage to biological resources, property, oil, gas or other mineral resource development activities, the environment (including, but not limited to, the human environment), impede, obstruct or adversely impact navigation or use of the waterway, have a detrimental effect on vessel safety, or if required for the dredging of the waterway;

2. the threat of harm or damage, the impediment or obstruction on navigation, or the detrimental effect on vessel safety exists within an unacceptable limit and cannot be eliminated or reduced to an acceptable limit within a reasonable period of time;

3. the economic advantages of cancellation outweigh the economic advantages of continuing either the AESL in effect or continued operations under the AESL.

D. Failure of the alternative energy source lessee to comply with an order of the board, or its authorized representative, to remove any and/or all equipment or suspend operations by the date specified, shall subject the lessee to a civil penalty of \$300 per day and shall continue to accrue on a daily basis until lessee complies with the order.

E. The civil penalty shall be paid into the Mineral and Energy Operation Fund on behalf of the board.

F. The state may remove any or all equipment whenever the lessee has failed to comply with the removal order of the board and the lessee shall reimburse the state for all necessary costs incurred.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:138 (January 2012), repromulgated LR 41:1758 (September 2015).

§948. Effect of a Suspension Order on an Alternative Energy Source Lease

[Formerly LAC 43:I.1148]

A. During the time the board, or its authorized representative, evaluates a lessee's request for removal of the suspension issued under §946 of this Chapter, the lessee must continue to fulfill its payment obligation until the end of the original term of the AESL. If the board or its authorized representative's evaluation goes beyond the end of the original term of the AESL, the term of the AESL shall be extended for the period of time necessary for the board, or its authorized representative, to complete its evaluation of the removal of suspension request. During this extended period of time, the lessee shall not be required to make payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:138 (January 2012), repromulgated LR 41:1759 (September 2015).

Subchapter D. Financial Assurance Requirements

§953. Financial Assurance Instrument

[Formerly LAC 43:I.1153]

A. Before the board may issue an AESL or approve an assignment of an existing AESL, the lessee or proposed assignee must provide either:

1. a lease-specific bond in an amount set by the board, in an amount no less than \$500,000;

2. an approved financial assurance instrument in the amount required in Paragraph A.1 of this Subpart and as authorized by the board pursuant to §955.

B. Each bond or other financial assurance must guarantee compliance with all terms and conditions of the AESL. The board may require the lessee to provide a new bond, or it may require the lessee to increase the amount of its existing bond to satisfy any additional financial assurance requirements. lessee shall comply with this requirement by providing either:

1. a certificate of deposit issued exclusively to DNR in a form prescribed by the board from a financial institution acceptable to the board;

2. a performance bond issued exclusively to DNR in a form prescribed by the board from a financial institution acceptable to the board;

3. a line of credit available exclusively to DNR, with DNR bearing no liability, in a form prescribed by the board issued by a financial institution acceptable to the board.

C. The board may require supplemental financial assurance in an amount determined by the board for a specific AESP.

D. The lessee will be considered in compliance with the financial assurance requirements under this Subpart if the lessee's designated lease operator provides a lease-specific bond in the amount required in Paragraph A.1. of this Subpart or other approved financial assurance that guarantees compliance with all terms and conditions of the AESL.

E. The dollar amount of the minimum, lease-specific financial assurance in Paragraphs A.1. and B. of this Subpart will be adjusted to reflect changes in the Consumer Price Index-All Urban Consumers ("CPI-U") or an industry-equivalent index if the CPI-U is discontinued.

F. No CPI-U adjustment may be made within the five year period following the adoption of this rule. Subsequent CPI-U based adjustments may be made every five years thereafter.

G. The lessee may not terminate the period of liability of the financial assurance instrument or cancel the financial assurance instrument. The financial assurance must continue in full force and effect even though an event has occurred that could diminish or terminate a surety's obligation under state law.

H. Evidence of financial assurance is required to be submitted by January 31 of each calendar year. Failure to submit updated evidence of financial assurance may cause the board, through OMR, to levy liquidated damages of \$100 per day until such evidence is received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:139 (January 2012), repromulgated LR 41:1759 (September 2015).

§954. Insurance Requirement

[Formerly LAC 43:I.1154]

A. The lessee shall purchase and maintain, for the duration of the AESL, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the lessee's operation and use of the leased premises. The cost of such insurance shall be borne by the lessee.

B. The lessee shall obtain at its own cost and expense the following insurance placed with insurance companies authorized to do business in the state with A.M. Best ratings of A-VI or higher. This rating requirement may be waived for workers compensation coverage only.

1. Workers Compensation. Workers Compensation Insurance shall be in compliance with the Workers Compensation Law of the state of the contractor's headquarters. Employers Liability is included with a minimum limit of \$500,000 per accident/per disease/per employee. If work is to be performed over water and

involves maritime exposure, applicable LHWCA, Jones Act, or other maritime law coverage shall be included and the Employers Liability limit increased to a minimum of \$1,000,000. A.M. Best's insurance company rating requirement may be waived for workers compensation coverage only.

2. Commercial General Liability. Commercial General Liability Insurance, including Personal and Advertising Injury Liability, shall have a minimum limit per occurrence of \$1,000,000 and a minimum general aggregate of \$2,000,000. The Insurance Services Office (ISO) Commercial General Liability Occurrence Coverage Form CG 00 01 (current form approved for use), or equivalent, is to be used in the policy. A claims-made form is unacceptable.

C. The General Liability Coverage policies shall contain, or be endorsed to contain, the following provisions.

1. The state, and its political subdivisions shall be named as an additional insured as regards negligence by the contractor and/or the lessee. ISO Form CG 20 10 (current form approved for use), or equivalent, is to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to the state, OMR, and the board.

2. The lessee's insurance shall be primary as respects the state, and its political subdivisions. Any insurance or self-insurance maintained by the state, OMR, and the board, shall be excess and non-contributory of the lessee's insurance.

3. Any failure of the lessee to comply with reporting provisions of the policy shall not affect coverage provided to the state, and its political subdivisions.

4. The lessee's insurance shall apply separately to each insured against whom claim is made or suit is initiated, except with respect to the policy limits.

D. The Workers Compensation and Employers Liability Coverage Policies shall contain, or be endorsed to contain, the following provisions.

1. The insurer shall agree to waive all rights of subrogation against the state, and its political subdivisions losses arising from or in connection with the lessee's operation and use of the leased premises.

E. The lessee shall provide verification of insurance coverage in the following manner.

1. The lessee shall furnish OMR with certificates of insurance reflecting proof of required coverage. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The certificates are to be received and approved by OMR before work commences and upon any AESL renewal thereafter.

2. In addition to the certificates, the contractor and the lessee shall submit the declarations page and the cancellation provision endorsement for each insurance policy. OMR reserves the right to request complete certified copies of all required insurance policies at any time.

3. Upon failure of the lessee to furnish, deliver and maintain insurance as provided above, the AESL, at the election of the board may be suspended, discontinued or terminated. Failure of the lessee to purchase and/or maintain any required insurance shall not relieve the lessee from any liability or indemnification.

F. All certificates of insurance of the lessee shall reflect the following.

1. The lessee's insurer will have no right of recovery or subrogation against the state, and its political subdivisions. It is the intention of the parties that the lessee's insurance policies shall protect both parties and shall be the primary coverage for any and all losses that occur under the AESL.

2. The state, and its political subdivisions shall be named as an additional insured as regards negligence by the contractor, the lessee or the operator of the AESP. ISO Form CG 20 10 (current form approved for use), or equivalent, is to be used when applicable.

3. The insurance companies issuing the policy or policies shall have no recourse against the state and its political subdivisions for payment of any premiums or for assessments under any form of the policy or policies.

G. If at any time an insurer issuing any policy does not meet the minimum A.M. Best rating, the lessee shall obtain a policy with an insurer that meets the A.M. Best rating and shall submit another certificate of insurance as required. Upon failure of the lessee to furnish, deliver and maintain insurance as provided above, the AESL, at the election of the board or OMR, may be suspended, discontinued or terminated. Failure of the lessee to purchase and/or maintain any required insurance shall not relieve the lessee from any liability or indemnification under the AESL.

H. Any deductibles or self-insured retentions must be declared to and accepted by OMR. Any and all deductibles shall be assumed in their entirety by the lessee.

I. All property losses caused by the actions of the lessee shall be adjusted with and made payable to the state of Louisiana.

J. The lessee or the lessee's insurer shall submit updated proof of insurance as required by this Subpart to OMR by January 31 of each calendar year. If lessee or lessee's insurer fails to submit proof, OMR may levy liquidated damages in the amount of \$100 per day until proof is received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:139 (January 2012), repromulgated LR 41:1759 (September 2015).

§955. Financial Assurance Amount Determination [Formerly LAC 43:1.1155]

A. The board's determination of the amount of the financial assurance required shall be based on estimates of the lessee's cost to meet all accrued lease obligations, including, but not limited to, decommissioning.

B. The amount of the supplemental and decommissioning financial assurance requirements, if required by the board, shall be determined on a case-by-case basis. The amount of the financial assurance shall be no less than the amount required to meet all lease obligations, including:

1. the projected amount of rent and other payments due to the state for a 12 month period commencing the date the funds become necessary;
2. any past due rent and other payments;
3. any other monetary obligations;
4. the estimated cost of facility decommissioning, as required in Subpart E of this Chapter.

C. If the lessee's cumulative potential obligations or liabilities increase or decrease, the board may adjust the amount of financial assurance or supplemental financial assurance required. In no event shall the board decrease the dollar amount less than the minimums required in §953 and §954 of this Chapter. If the board proposes adjusting the amount of financial assurance required, OMR will notify the lessee of the proposed adjustment and provide the lessee an opportunity to comment.

D. Based on the information and statements provided by the lessee at the hearing, the board may modify the dollar amount required. The board may not modify the dollar amount required below the minimums required in §953 and §954 of this Subpart.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:140 (January 2012), repromulgated LR 41:1760 (September 2015).

§956. Bankruptcy or Lapse of Financial Assurance or Insurance
[Formerly LAC 43:I.1156]

A. If the lessee becomes bankrupt or insolvent, or if the approved financial assurance expires for any reason, the lessee shall:

1. notify the board or its authorized representative within five business days of the expiration of existing financial assurance and/or insurance. Lessee's failure to renew or obtain new financial assurance and/or insurance prior to the expiration of existing financial assurance and/or insurance shall automatically suspend all rights granted to the lessee under the AESL. Lessee's failure to obtain coverage within 90 days after termination of the required security and/or insurance shall result in termination of the AESL;

2. notify the board or its authorized representative within five business days of the initiation of any judicial or administrative proceeding alleging insolvency or bankruptcy;

3. notify the board or its authorized representative within five business days after the lessee learns of any action filed alleging that the lessee's surety, or third-party guarantor, is insolvent or bankrupt.

B. If the approved financial assurance and/or insurance expire for any reason:

1. prior to the cancellation of the security or insurance required by this Subpart, if the lessee does not provide the Lessor evidence that a new security or insurance has been obtained meeting all of the requirements of this Subpart, all rights granted to the lessee under the AESL shall automatically and, without further notice to the lessee, be suspended;

2. the lessee shall immediately suspend operations under the AESL except for those operations necessary to maintain the safety of already ongoing operations. The lessee shall provide evidence to the board or its authorized representative by providing sufficient documentation demonstrating the reinstatement of the requisite security and/or insurance;

3. upon the reinstatement of the requisite security and/or insurance, the lessee will be allowed to resume operations;

4. should lessee fail to obtain coverage within 90 days after termination of the required security and/or insurance, the AESL shall terminate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:140 (January 2012), repromulgated LR 41:1761 (September 2015).

§957. Financial Assurance Company Rating
[Formerly LAC 43:I.1157]

A. The financial assurance must be supplied by a company to whom A.M. Best Company has given not less than an "A" rating.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:141 (January 2012), repromulgated LR 41:1761 (September 2015).

Subchapter E. Decommissioning Requirements
§961. Decommissioning Liability
[Formerly LAC 43:I.1161]

A. Lessees, successors and/or assignees are jointly and solidarily responsible for meeting the decommissioning obligations for facilities on each AESL, including all obstructions, as the obligations accrue and until each obligation is met.

B. The decommissioning obligation will begin when a lessee, sub-lessee, assignee, or successor installs, or constructs equipment for the AESP, including, but not limited to, a facility, turbine, support structure, cable, or pipeline, or when the lessee, sub-lessee, assignee, or successor creates an obstruction to other uses of state lands or water bottoms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:141 (January 2012), repromulgated LR 41:1761 (September 2015).

§962. Decommissioning General Requirements
[Formerly LAC 43:I.1162]

A. Before decommissioning the facilities under an AESL, the lessee shall submit a decommissioning application and receive approval from the board or its authorized representative.

B. Following approval of the decommissioning application, the lessee shall submit a decommissioning notice at least 15 days prior to commencement of decommissioning activities. The decommissioning shall begin no later than 45 days following the approval of the decommissioning application.

C. Within one year following termination of an AESL, the lessee shall:

1. remove or decommission all facilities, turbines, support structures, cables, pipelines, and obstructions associated with the AESL;

2. clear the waterway and the water bottoms of all obstructions created by alternative energy source activities on the leased area. The board may require the lessee to immediately remove any and all obstructions effecting navigation and commerce of the waterway.

D. If the lessee, sub-lessee, assignee, successor, subcontractor, or any agent acting on behalf of lessee

discovers any archaeological resource while conducting decommissioning activities, the party performing the decommissioning activities shall immediately cease bottom-disturbing activities within 1,000 feet of the discovery and report the discovery to the board, through OMR, within 72 hours of the discovery. Any party having knowledge of the discovery shall keep the location of the discovery confidential, except to report it to OMR, and shall not take any action that may adversely affect the archaeological resource unless instructed by OMR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:141 (January 2012), repromulgated LR 41:1761 (September 2015).

§963. Decommissioning Application Time Requirements

[Formerly LAC 43:I.1163]

A. The lessee shall submit a decommissioning application upon the earliest of the following dates:

1. two years prior to the expiration of the AESL;
2. ninety days after completion of the commercial activities on an AESL;
3. ninety days after cancellation, relinquishment, or other termination of the AESL.

B. Lessee shall justify any difference(s) existing between the decommissioning application and the approved COP submitted pursuant to §935 of this Chapter.

C. The board may reject any proposed modification to the decommissioning plan as submitted and approved in the COP and require the lessee to comply with the most stringent plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:141 (January 2012), repromulgated LR 41:1762 (September 2015).

§964. Decommissioning Notice

[Formerly LAC 43:I.1164]

A. The board, through OMR, shall advertise notice of the receipt of any decommissioning application pertaining to an AESL in the local newspaper where the AESL is located and in the official state journal. Such advertisement shall identify:

1. the title and address of OMR.;
2. the name, title, address, and telephone number of an OMR representative from whom additional information and/or documentation may be obtained;
3. the name and address of the entity submitting the decommissioning application;
4. the name and physical location of the affected facility;
5. the name of the affected waterway;
6. the activities involved in the decommissioning action;
7. the most recent approved decommissioning plan;
8. a brief description of the appropriate comment procedures;
9. the date, time and place of any scheduled hearing;
10. the procedure(s) for requesting a hearing.

B. The board, through OMR, shall provide at least 30 days for public comment.

C. The board, through OMR, shall provide notice of the proposed decommissioning application to each affected state agency and Port Authority within five business days of receipt of the decommissioning application. The comment period for affected state agencies and Port Authorities shall expire at the close of the public comment period.

D. The board may refuse to accept any recommendations for the decommissioning application submitted by a state agency and/or Port Authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:142 (January 2012), repromulgated LR 41:1762 (September 2015).

§965. Decommissioning Application Information Requirements

[Formerly LAC 43:I.1165]

A. The lessee, sub-lessee, assignee, or successor shall include the following information in the decommissioning application:

1. Identification of the applicant, including:
 - a. names and addresses of the lease operator and lessee;
 - b. name and telephone number of lessee's contact person;
 - c. name, address, telephone number, and name of contact of the companies which issued the required financial assurance instruments and required insurance.
 2. Identification and description of the facilities, turbines, support structures, cables, and/or pipelines lessee plans to remove or proposes to leave in place.
 3. A proposed decommissioning schedule for the lease, including the expiration or relinquishment date and proposed month and year of removal.
 4. A description of the removal methods and procedures, including the types of equipment, vessels, and moorings to be removed (e.g., anchors, chains, lines).
 5. A description of the lessee's site clearance activities.
 6. The lessee's plans for transportation and disposal or salvage of the removed facilities, turbines, support structures, cables, or pipelines and any required approvals.
 7. A description of any resources, conditions, or activities that could be affected by or could affect the proposed decommissioning activities. The description shall confirm compliance with the National Environmental Protection Act ("NEPA") and other relevant federal, state and local laws.
 8. The results of any recent biological surveys conducted in the vicinity of the leased area.
 9. Mitigation measures secured to protect archaeological and sensitive biological features during removal activities.
 10. A description of measures to prevent the unauthorized discharge of pollutants, including marine or riverine trash and debris, onto state lands or into waters.
 11. A determination of lessee's intent to use divers to survey the leased area after removal.
- AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.
- HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:142 (January 2012), repromulgated LR 41:1762 (September 2015).

§966. Process of Decommissioning Application
[Formerly LAC 43:I.1166]

A. Upon lessee's compliance with §1165 of this Chapter, OMR or other state agencies may request a technical and environmental review based on a comparison of the decommissioning application and the decommissioning general concept in the approved COP.

B. The lessee may be required to revise the COP and begin the appropriate NEPA analysis and/or other regulatory reviews, as required, if OMR or other state agencies determine that the lessee's decommissioning application would:

1. result in a significant change in the impacts previously identified and evaluated in the COP;
2. require any additional federal or state permits;
3. propose activities not previously identified and evaluated in the COP.

C. During the review process, OMR or other state agencies may request additional information if it determines that the information provided is insufficient to complete the review process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:142 (January 2012), repromulgated LR 41:1763 (September 2015).

§967. Decommissioning Removal Requirements
[Formerly LAC 43:I.1167]

A. The lessee must remove all equipment, including, but not limited to, facilities, turbines, support structures, pipeline, and cables, and shall comply with the decommissioning requirements as set forth by the U.S. Army Corps of Engineers. The lessee shall also comply with any additional or more stringent decommissioning requirements mandated by the board, through OMR.

B. Within 60 days after the removal of a facility, the lessee shall verify to the board, through OMR, that it has removed all equipment required to be removed and that it has cleared the state lands and water bottoms of all obstructions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:142 (January 2012), repromulgated LR 41:1763 (September 2015).

§968. Decommissioning Report
[Formerly LAC 43:I.1168]

A. Within 60 days after lessee has completed the decommissioning requirement and has restored the lease site by the removal of all alternative energy source equipment, including, but not limited to, facilities, turbines, support structures, cables, or pipelines, lessee shall submit a written report to the board, through OMR, that includes the following:

1. a summary of the removal activities, including the date removal activities were completed;
2. a description of any mitigation measures taken by lessee;

3. if lessee used explosives, a statement signed by lessee's authorized representative certifying that the types and amounts of explosives utilized were consistent with those in the approved decommissioning application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:143 (January 2012), repromulgated LR 41:1763 (September 2015).

§969. Failure to Comply with Decommissioning Requirements
[Formerly LAC 43:I.1169]

A. The lessee shall comply with the decommissioning requirements as set forth in the approved decommissioning plan. If lessee fails to comply with the decommissioning requirements:

1. the board shall require the lessee to forfeit the financial assurance provided pursuant to §953 and §955 of this Chapter;

2. the lessee shall remain liable for the removal or disposal costs and shall be responsible for all accidents or damages, including reasonable attorney fees expended by the state to defend claims resulting from lessee's failure to comply with decommissioning requirements;

3. the board, or its authorized representative, may take legal action to enforce the decommissioning requirements. The lessee shall be liable for all reasonable attorney fees expended by the board or its authorized representative required to enforce the decommissioning obligations;

4. the lessee shall remain the owner of all facilities and/or equipment installed and used in the alternative energy project. The state shall have the right to remove any and all of the facilities and/or equipment at the expense of the lessee.

B. Failure of the alternative energy source lessee to comply with decommissioning obligations to remove all equipment by the date specified in the approved decommissioning plan shall subject the lessee to a civil penalty of \$300 per day and shall continue to accrue on a daily basis until the date the lessee has complied with the decommissioning obligation.

C. The civil penalty shall be paid into the Mineral and Energy Operation Fund on behalf of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:143 (January 2012), repromulgated LR 41:1763 (September 2015).

Subchapter F. Special Hydrokinetic Rules

§975. FERC Authority

[Formerly LAC 43:I.1175]

A. This Subpart shall apply only to hydrokinetic energy source projects which fall under the jurisdiction of the Federal Energy Regulatory Commission pursuant to the Federal Power Act, 16 U.S.C. 791a, et seq.

B. In the event there is a conflict with the requirements of this Subpart with any requirements under Chapter 11, the requirements set forth in this Subpart shall govern.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:143 (January 2012), repromulgated LR 41:1763 (September 2015).

§976. Hydrokinetic Lease Compliance
[Formerly LAC 43:I.1176]

A. All applicants must first obtain approval by FERC for the issuance of a preliminary permit, license, exemption, or other authorization for the development of hydrokinetic energy. The lessee may use the documents submitted and approved by FERC to satisfy the following requirements.

1. The COP may satisfy the requirements of §921 of this Chapter.

2. The Coast Guard recommendations may satisfy the requirements of §922 of this Chapter and any information required concerning navigational safety and maritime security.

3. The report on fish, wildlife, and botanical resources may satisfy the information required of §935.C.3.h of this Chapter to determine the project's impact and mitigation required to protect the fish, wildlife and botanical resources.

4. The report on historical and archaeological resources may satisfy the information required of §935.C.9 of this Chapter to determine the project's impact and mitigation required to protect the historical and archaeological resources of the area.

5. The report on socio-economic impacts may satisfy the requirements of §935.C.3.h of this Chapter.

6. The report on environmental impact may satisfy the requirements of §932.A.5 and §935.C.4 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:143 (January 2012), repromulgated LR 41:1764 (September 2015).

§977. Submission of Bid for Hydrokinetic Energy Source Lease
[Formerly LAC 43:I.1177]

A. All interested registered parties who hold a valid preliminary permit, license, exemption, or other authorization issued by FERC pursuant to its authority under the Federal Power Act, 16 U.S.C. 791a, et seq., shall submit a bid package on the entirety of the State tract nominated and advertised for State hydrokinetic energy source lease to the board, through OMR, in the form OMR requires by the advertised deadline. Each bid package shall be accompanied by any other documentation and information required.

B. An official bid form is available from OMR. Applicant must provide one originally signed paper copy and no electronic copy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:124.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Mineral Resources, LR 38:143 (January 2012), repromulgated LR 41:1764 (September 2015).

Gus C. Rodemacher
Assistant Secretary

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RULE

Department of Public Safety and Corrections
Corrections Services

Offender Visitation (LAC 22:I.316)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, has amended the contents of Section 316, Offender Visitation.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT

Part I. Corrections

Chapter 3. Adult Services

Subchapter A. General

§316. Offender Visitation

A. Purpose—to state the secretary's policy regarding offender visitation and to set forth the process through which offenders may receive visits from persons outside the department in order to maintain contact and relationships in the community. The visiting process shall be conducted at each facility with as much uniformity and consistency as possible while considering the physical limitations and security needs of each facility.

B. Applicability—deputy secretary, chief of operations, regional wardens and wardens. Each warden is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation and for conveying its content to all offenders, affected employees and visitors.

C. Policy. The department understands the importance of visitation in the maintenance of an offender's family ties; visitation is an integral component of institutional management. The department recognizes that the majority of offenders will be released into the community and that the offender's eventual reintegration will be more effective if a visitation program permits the maintenance of social relationships. Visiting can improve public safety and encourage offender accountability. Authorized visitation is permitted by the department to facilitate an offender's institutional adjustment in accordance with the department's goals and mission. The visiting process shall be conducted in an atmosphere that is conducive for the safe, secure and orderly management and operation of the institution. Thus, the visiting process will not overly tax the institution's resources or its ability to maintain adequate control and supervision. In this matter, as in all others affecting institutional operations, safety and security are primary considerations. Any restrictions placed on visiting privileges pursuant to this regulation are rationally related to legitimate penological interests.

D. Definitions

Attorney Visit—visit by an attorney or authorized representative, such as a paralegal, legal assistant, law clerk and investigator whose credentials have been verified.

Contact Visit—a visit in which the offender and visitor(s) are not physically separated.

Contraband—

a. for the purpose of this regulation, includes possession of any weapon, firearm, ammunition or any other item detrimental to the security of the facility, cellular phone or component hardware or other electronic communications device, whether operational or not, (including but not limited to beepers, pagers, subscriber identity module (SIM) cards, portable memory chips, batteries for these devices, chargers, or global satellite system equipment), illegal drug or alcohol, a positive drug screen, failure to provide a urine sample within three hours of being ordered to do so, a positive breathalyzer test or refusal to submit to a drug or alcohol test;

b. in addition, any offender who attempts to destroy or hide contraband or in any way interferes in a correctional officer's attempt to seize contraband (i.e., flushing drugs down the toilet, pushing an officer to pass contraband to another offender, throwing the contraband over a fence or out of a window, etc.) will be deemed to be in possession of contraband for the purpose of this regulation. (In such cases, the correctional officer must explain the evasive conduct and the presumed contraband in precise and specific detail in the unusual occurrence report (UOR)).

Court Ordered Visit—provides for visitation rights of an incarcerated parent with a minor child.

Disrespect—hostile, sexual, abusive, threatening language or gestures, verbal or written, towards or about another person by a visitor.

Disturbance—conduct or activity which unnecessarily interferes with visitation operations, and/or which advocates, encourages, promotes or otherwise creates or poses a threat to the safety, security, health and good order of the institution, and/or the safety and security of offenders, staff or visitors. A visitor commits a disturbance if the visitor advocates, creates, engages in, maintains or promotes an annoying condition or disorder characterized by unruly, noisy or violent conduct.

Employee—any person employed full-time, part-time or on temporary appointment by the department.

Excessive Contact—prolonged or frequent physical contact between a visitor and an offender that exceeds the brief embrace and kiss upon meeting and leaving and hand-holding. Excessive is not casual contact, but rather a pattern of contact beyond rule limits.

Immediate Family Member—includes the offender's father, mother, siblings, legal spouse, children, grandparents, grandchildren, aunts, uncles, and legal guardians including those with a "step," "half" or adoptive relationship and those persons with the same relationship of the offender's legal spouse and any others indicated on the offender's master record as having raised the offender.

Intake Status—the 30-day period of time following delivery of an offender to the custody of the department. During this time, staff conducts intake processing of the offender including, but not limited to, medical and mental health assessments, custody classification and identification of programming needs and assignments.

Minor Child—anyone under the legal age of majority (18 years).

Non-Contact Visit—a type of visitation whereby an offender and an approved visitor on the offender's visiting list are not permitted to be in physical contact during

visitation and are generally separated by a physical barrier. Non-contact visit may also include video visitation (see video visitation definition below).

Picnic Visit—a type of visitation in an area of the institution set aside for picnicking.

Regular Visit—visitation whereby an offender and an approved visitor on the offender's visiting list are permitted to see and talk with each other on a scheduled basis for a reasonable period of time with limited physical contact, consisting of a brief embrace and kiss upon meeting and leaving, hand-holding and holding of children.

Sex Crime Involving a Minor Child—any conviction of a sexual crime committed, attempted or conspired in which a minor child was involved, victimized or was the intended victim.

Special Visits—

a. a visit that is permitted at an hour and/or place at which visits are not normally permitted;

b. an extra visit by an offender and a person who is on the offender's approved visiting list that is permitted beyond the limits of the number of visits established by this regulation and institutional policy and procedures;

c. a visit with a person who is not on the offender's approved visiting list, such as out-of-state family members or friends;

d. a visit that is authorized for hospitalized or terminally ill offenders.

Suspension of Visiting Privileges—the taking away of visiting privileges for a determinate period of time due to either the visitor's conduct (which may include denial of the visitor at all department facilities) and/or due to the offender's conduct (which may include denial of all visits to that offender, excluding approved clergy, attorney visits and special visits).

Video Visitation—a method of visitation which allows offenders to visit through electronic media.

E. Treatment of Visitors

1. There shall be no discrimination in visiting. All visitors and offenders shall be provided equal opportunities in visiting in accordance with the offender's security classification and housing assignment.

2. Visitors shall be treated with courtesy at all times and shall not be subjected to unnecessary delay or inconvenience in accomplishing a visit.

3. All visitors with disabilities shall have readily accessible facilities and shall be reasonably accommodated as appropriate and to the extent possible within the context of the department's fundamental mission to preserve the safety of the public, staff and offenders. Advance notice of the accommodation requested shall be necessary to ensure its availability at the time of the visit.

F. Designated Visiting Areas

1. Visiting Room

a. Each facility, except reception centers (for offenders in intake status see Subparagraph H.1.b), shall designate at least one location that shall be used for offender visitation. This area(s) shall be in a location(s) that ensures the safety and security of the facility and the persons involved.

2. Visiting Children's Area

a. Wardens shall take into consideration the impact that visits with parents or grandparents in a correctional

setting may have on young children, especially pre-school age children. When possible and taking into consideration the physical environment and space capabilities, the visiting area(s) shall make special accommodations to entertain and occupy the minds of these children. These accommodations may include a separate room adjoining the main visiting area which is bright, inviting and comfortable or a similar space within the main visiting room. Appropriate age books, games and toys may be available in these areas. At all times, children must be supervised by the offender who is being visited or the adult visitor who brought the children. The use of this type of area shall be accomplished without the need for additional staff to supervise the area.

3. Contact or Non-Contact Visiting Areas

a. Unit-specific operational procedures shall designate the location(s) for offender visitation and whether the areas shall permit "contact" or "non-contact" visits.

G. Application for Visitation

1. Application Process

a. In order for family members and friends to visit offenders, they must complete an application for visiting privileges. Offenders shall be responsible for sending applications to family members and friends they want to visit. It is the offender's responsibility to provide the correct name, address, date of birth, race and sex of all prospective visitors. Each warden shall designate a staff person to receive and process these applications.

b. All prospective visitors must complete the application and mail it to the facility the visitor wishes to visit. Parents/legal guardians shall be required to complete the application for minor children (under the age of 18) and shall sign the application on behalf of the minor child. Faxes of the application are not acceptable. It is important that the application be completed fully and all questions answered honestly. Failure to provide all requested information may result in a delay in the processing of the application or a denial of visiting privileges.

2. Criminal History Screening

a. A criminal history background check shall be conducted on each adult applying to visit an offender. In addition, approved adult visitors shall be re-screened for criminal history every two years in accordance with the provisions of this section. Screening may be conducted through one of the following methods:

- i. criminal history background questionnaire to local law enforcement;
- ii. CAJUN 2 inquiry;
- iii. National Crime Information Center (NCIC); or
- iv. Louisiana computerized criminal history (LACCH).

b. The warden retains the option of choosing the method of obtaining the criminal history that best meets the needs of the institution.

c. When an active criminal warrant is found, the application shall be reviewed and local law enforcement shall be notified of the information provided. The information on the applicant's criminal history is treated as confidential and shall not be released to the offender.

3. Notification of Approval/Denial

a. Once a decision is made either approving or denying the application, the offender shall be notified. The offender is responsible for advising applicants that their

applications have been approved or denied. The applicant's approved application must be on file prior to visiting.

H. Eligibility for Visitation Privileges

1. Offenders

a. All offenders, (except those offenders in intake status see Subparagraph H.1.b) or as specifically provided herein, are eligible to apply for visits while confined in a departmental facility.

b. Offenders in Intake Status

i. Visitation will not be allowed while an offender is in intake status. If the intake process exceeds 30 days, the offender may request a special visit with immediate family members in accordance with the reception center's visiting procedures. Once an offender is removed from intake status, visitation with immediate family members may be authorized by the receiving facility at the request of an offender.

c. Offenders With No Established Visiting Record

i. Offenders entering an institution with no established visiting record should be granted tentative approval to visit immediate family members upon the request of the offender. Verification of relationship may be required. Exceptions must be approved by the warden or designee and be based upon legitimate security considerations.

d. Offenders Transferred to Another Facility

i. Offenders transferring to another institution should be authorized to visit with their approved visitors at the receiving institution unless it is demonstrated that the requirements/restrictions of this regulation were not previously adhered to in the approval process or unless the warden or designee at the receiving institution identifies the need to apply restrictions based upon current security considerations. (An offender shall be allowed to request a change in his visiting list when he first arrives at the receiving institution and at four-month intervals thereafter.)

2. Prospective Visitors

a. All persons, except as specifically prohibited in accordance with this regulation, are eligible to be considered for approval to visit an offender confined in a departmental facility upon application and request by the offender.

b. Visitation by Individuals with Criminal Conviction/Pending Criminal Charges

i. A person is ineligible to visit if the individual has been convicted of, and/or has criminal charges pending against him for the following crimes/criminal activities:

(a) introduction and/or supplying, attempting or conspiring to introduce or supply contraband;

(b) possession, control or delivery of an explosive device or substance, including attempt or conspiracy to do the same; or

(c) assisting an offender in an escape or unlawful departure from a correctional facility, including an attempt or conspiracy.

c. Visitation by Victims

i. Visits from the offender's direct victim(s) are prohibited except in accordance with established procedures. At the warden's discretion, this policy may be waived on a case-by-case basis.

d. Visitation by Ex-Offenders/Parolees/Probationers

i. A person who has been convicted of a felony, who has not been finally discharged from an institution or

from probation or parole supervision for more than two years without an intervening criminal record shall be denied approval to be placed on an offender's visiting list. In addition, any person who in the previous five years had three or more felony charges (regardless of disposition) shall be considered ineligible to visit or, if already an approved visitor, shall have visiting privileges revoked.

e. Visitation by Staff/Ex-Employees

i. Visitation by employees of the department is reserved for immediate family members only. Requests to visit an incarcerated family member shall be submitted to the requesting employee's warden or designee for consideration. A departmental employee or an ex-employee may be denied approval to visit if such denial is deemed by the warden or designee to be in the best interest of the institution.

f. Exceptions

i. Exceptions to the provisions of this Section, including the approval of former offenders as visitors, may be specifically authorized by the warden or designee.

I. Visits with Minors

1. Restriction on Visits with Minors

a. Offenders who have a current or prior conviction for a sex crime involving a minor child family member, or who have a documented history of sex abuse with a minor child family member, are ineligible to visit with any minor child, including their own biological or step-child (see Subparagraph I.1.c and Paragraph 2 for possible exceptions).

b. Offenders who have a current or prior conviction for a sex crime involving a minor child who is not a family member are ineligible to visit with any minor child. However, at the warden's discretion, such offenders may be authorized to visit with their own biological child. The legal guardian shall submit a written request and shall accompany the minor child during the visit. If approved by the warden, the visit may be contact or non-contact at the warden's discretion. The legal guardian may be permitted to name another individual (other than the legal guardian) who is on the offender's visiting list to accompany the minor child for a visit. The legal guardian shall provide a written, notarized statement authorizing a specific individual to accompany the minor child. If approved by the warden, the visit may be contact or non-contact at the warden's discretion (see Subparagraph I.1.c and Paragraph 2 for possible exceptions).

c. Visits for offenders who have successfully completed or are participating satisfactorily in sex offender treatment may be considered by the warden. (Treatment staff who teach the sex offender class shall be involved in the decision-making process for this type of visit.) The legal guardian shall submit a written request and shall accompany the minor child during the visit. The legal guardian may be permitted to name another individual (other than the legal guardian) who is on the offender's visiting list to accompany the minor child for a visit. The legal guardian shall provide a written, notarized statement authorizing a specific individual to accompany the minor child. If approved by the warden, the visit may be contact or non-contact at the warden's discretion.

d. Minor children may be prohibited from participating in non-contact visits at the discretion of the warden.

e. Each visit with a minor child shall be documented in the offender's visiting record.

2. Court-Ordered Visitation

a. Pursuant to the provisions of Act No. 383 of the 2014 Regular Session, a court may authorize visitation with an incarcerated parent. As part of such visitation order, the court shall include restrictions, conditions and safeguards as are necessary to protect the mental and physical health of the child and minimize the risk of harm to the child. In considering the supervised visitation of a minor child with an incarcerated parent, the court shall consider the best interests of the child.

b. In cases of court ordered visitation, the department cannot deny the visit. However, such visitation shall be in conformance with all other rules and regulations that pertain to visiting.

c. For the purpose of this Section, "court" means any district court, juvenile court or family court having jurisdiction over the parents and/or child at issue.

J. Establishing and Maintaining Visiting Lists

1. Approved Visitors

a. Offenders may be permitted a maximum of 10 approved visitors on their respective visiting lists. The initial request for visitors shall be used by offenders to request visitors.

b. At the discretion of the warden or designee, an offender participating in a special recognition program may be allowed to have up to a maximum of 15 approved visitors placed on his visiting list.

c. The name of each approved visitor shall appear on the offender's visiting list; however, legal advisors, one approved religious advisor and minor children shall not be counted toward the maximum number of approved visitors, although the names of the legal advisors and one approved religious advisor shall still appear on the list. The names of the minor children need not appear on the list.

d. Except as noted in Paragraph I.1 relative to offenders who have a current or prior conviction for a sex crime, minor children may visit on any of the regular visiting days when accompanied by an adult visitor on the offender's approved visiting list. Both visitors must be visiting the same offender at the same time. Exceptions to being accompanied by an adult may be specifically authorized by the warden or designee, including, but not limited to, the following:

- i. minor spouse;
- ii. emancipated minors (judgment of emancipation required as proof); or
- iii. minors visiting as part of approved institutional programs such as school groups, church groups, parenting groups, etc.

2. Changing the Visiting List

a. Each offender shall be allowed to request changes (additions, deletions, substitutions) to his approved visiting list every four months.

b. A request for changes to approved visiting list shall be made available to offenders to request changes to their approved visiting list.

K. Visiting Rules

1. Visiting Privileges

a. Visitation is a privilege and not a right. Violation of rules may result in termination of the visit, loss of the offender's visiting privileges, banning of the visitor from

entering the institution or its grounds and/or criminal charges as circumstances warrant.

2. Unit-Specific Visiting Procedures

a. This regulation and the department's standard guidelines for visitors are available on the department's website at www.doc.louisiana.gov. Information specific to each facility is also posted on the department's website (i.e., driving directions, visiting days/hours, special visits, etc.).

b. Each warden shall be responsible for ensuring written information regarding unit specific visiting procedures is made available to offenders within 24 hours following the offender's arrival at the institution. At a minimum, the information shall include, but is not limited to, the following:

- i. address and phone number of the institution;
- ii. directions to the institution;
- iii. information regarding local transportation;
- iv. days and hours of visitation;
- v. approved dress code;
- vi. authorized items;
- vii. rules for children and special visits.

3. Visitor Identification Requirements

a. All visitors age 18 years and older shall be required to produce valid picture identification before entering the visiting area each time they visit. The only forms of identification accepted by the department are:

- i. a valid driver's license from the state of residence;
- ii. a valid state photo identification card from the state of residence;
- iii. a valid military photo identification card (active duty only);
- iv. a valid passport.

4. Refusal/Requests for Removal

a. Offender Refusal to Visit

i. An offender may refuse to see a visitor; however, the offender shall be required to sign a statement to that effect and the statement shall be filed in the offender's master record. Should the offender refuse to sign a statement, documentation of the refusal shall be placed in the offender's master record.

b. Requests for Removal

i. A person may be removed from the offender's approved visiting list at his own request or at the request of the offender. If a visitor requests such removal, the visitor must wait six months before applying to visit the same or another offender. Exceptions may be made for immediate family members.

5. Visitors may only be on one offender's visiting list.

a. A visitor can be on only one offender's visiting list per institution unless that visitor is a family member of more than one offender. The burden of proof and documentation shall be the responsibility of the offender and his family. Visitors may request that they be removed from one offender's visitor's list and placed on another offender's list in accordance with this regulation.

6. Number, Duration and Conditions of Visits

a. Approved visitors should be allowed to visit the offender at least two times per month.

b. While a two-hour visit is optimum, each warden or designee retains the discretion to determine the duration of visits, as well as the days and hours on which they may

occur. Available space and staff shall determine visiting lengths.

c. Each warden or designee retains the discretion to determine the number of visitors who may visit an offender at one time. Family visiting and contact visits are to be permitted to the extent possible.

d. All visitors are to be informed in writing of the rules governing visiting (see "Guidelines for Visitors"). Visiting guidelines shall be conspicuously posted in the visiting areas and are made available to prospective visitors on the department's website at www.doc.louisiana.gov.

e. Visitors are allowed to bring only enough cash money for vending machines and/or concessions into the visiting area. Financial transactions for offenders shall be in the form of cash and/or credit or debit card payments made at the unit's visitor center kiosk machines provided by the department's contractor for offender services for use by the offender's approved visitors. All other money from permissible sources may be accepted and processed in accordance with established procedures.

NOTE: Contractor fees shall apply to this transaction.

f. Any visit may be terminated if the offender or visitor violates the rules governing visiting.

g. Where available, picnic visits are authorized as approved by the warden or designee. The warden or designee shall authorize foods that will be allowed for picnics.

7. Special Visits

a. Special visits may be granted, with the prior approval of the warden or designee, on a case-by-case basis. Unit operational procedures shall specify the parameters for such approval, with consideration given to sources of transportation, accessibility to the facility by visitors, the distance a visitor must travel and any special circumstances.

8. Dress Code for Visitors

a. Visitors shall be made aware that visiting areas are designed to cultivate a family atmosphere for family and friends of all ages. Visitors shall dress and act accordingly. Visitors shall wear clothing that poses no threat to the safety, security, good order and administrative manageability of the facility. See "Guidelines for Visitors" for specific dress standards.

L. Video Visitation

1. Video visitation is considered a special visit and shall be requested and approved in accordance with Paragraph K.7 and shall be in conformance with all other rules and regulations that pertain to visiting.

2. When transportation is provided during emergencies and extreme circumstances, offenders may be allowed to visit via video connection capabilities.

3. The warden or designee shall ensure that all laptops, laptop connection cards or wireless internet connection cards are maintained in a secure location that is not accessible to offenders and other unauthorized or untrained persons when not in use.

4. The warden or designee may approve the set-up and use of video visitation and shall ensure that a staff member or approved volunteer is assigned to monitor the visit at an appropriate, conducive visitation area.

5. The warden or designee shall be responsible for ensuring that staff and/or volunteers are present at the remote location. Staff and/or volunteers at the remote

location shall document that they and the approved visitor(s) are the only individuals present for the video visitation.

6. Any other person present is required to have written permission from the warden or designee to participate in the video visitation process.

7. Violations occurring during video visitation are subject to disciplinary action, suspension of visiting privileges and/or possible civil or criminal prosecution, depending on the nature of the offense.

8. This form of visiting involves open internet capability requiring on-site supervision at both locations when in use and does not involve or allow connection to the department's network.

M. Visitation Records

1. Each facility shall maintain a record for each offender documenting all of the offender's visits. All visiting records/information obtained on an offender by institutional staff shall be transferred with the offender when the offender is reassigned to another institution within the department. This includes transfers to transitional work programs. The offender's current visiting information shall be utilized by the transitional work program to allow for visitation.

N. Visitor Searches

1. Without warning, visitors are subject to a search of their vehicles, possessions and persons. This is necessary to preclude the introduction of weapons, ammunition, explosives, cell phones, alcohol, escape devices, drugs, drug paraphernalia or other prohibited items or contraband into the prison environment. All searches of visitors shall be conducted in accordance with established procedures.

2. Signs shall be posted in the area(s) where visitors are initially processed and in the visiting rooms/areas that advises visitors that drug detection dogs (K-9's) may be in use at the facility and visitors shall be subject to search by these dogs. The sign shall state:

NOTICE: Drug detection dogs (K-9's) may be in use today in the visiting room. These dogs are non-aggressive. All visitors will be searched prior to entering the visiting room and/or during the visit. If you do not wish to be searched, you may choose not to visit today.

O. Supervision of Visiting Areas

1. Facilities shall provide direct visual supervision of the entire visitation area at all times. Staff shall position themselves throughout the visitation area to maintain a direct line of sight on interactions between offenders and visitors. While mirrors and cameras can augment direct supervision and compensate for blind spots, staff shall position themselves with a direct line of sight on interactions between offenders and visitors.

2. Staff shall immediately intervene on inappropriate behavior, which may include behavior outside the bounds of permitted intimacy or involve any violation of visiting regulations that may prove uncomfortable, disruptive, or offensive to other offenders and visitors.

3. Notices shall be posted informing visitors of the potential for monitoring anywhere in the visiting area. Staff of the same gender as the visitor shall monitor the restrooms during visits if there is reasonable suspicion that a visitor or offender may engage or be engaging in some form of prohibited behavior.

P. Visitation at Special Offender Organization Functions/Events

1. The warden may authorize offender organizations to hold special functions or events when those programs can be adequately supervised by staff. When such a special function is approved by the warden, visitors to the event shall be subject to the normal security processing as would occur during normal hours of visitation. Special guests (speakers/presenters) invited to the special function shall be processed at the direction of the warden.

Q. Emergency Situations

1. When the warden or designee determines that an emergency situation exists at the facility, any or all visits shall be suspended. Any visits in progress shall be terminated and the visitors escorted from the facility. Any person may be denied permission to visit during the time of a disturbance at the institution. All visiting shall be suspended during an emergency.

R. Limitation or Suspension of Visiting Privileges

1. Non-Contact Visits

a. Offenders who are housed in administrative segregation or disciplinary units shall be placed on non-contact visitation status if physical plant space is available.

b. Any offender who pleads guilty or has been found guilty of a schedule B disciplinary rule violation for one or more of the following reasons shall be subject to non-contact visits for a minimum of six months:

- i. possession of any drug or drug paraphernalia;
- ii. producing a positive or adulterated urine sample;
- iii. refusal or substantial delay to provide a urine sample;
- iv. introduction of contraband into the institution;
- v. positive breathalyzer test;
- vi. repeated (defined as more than two in a two year time period) violations of disciplinary rule no. 21; or
- vii. any major rule violation that occurs in the visitation area.

c. Such restriction must be formally reviewed by an appropriate board at a minimum of every six months.

d. Restriction of contact visiting is not a disciplinary penalty.

2. Suspension of an Offender's Visiting Privileges (No Visiting)

a. Any offender who pleads guilty or has been found guilty of a contraband charge (as defined in Subsection D of this regulation) for the first time shall have all visiting privileges suspended for a maximum of six months, excluding approved clergy, attorney visits and special visits.

b. Any offender who pleads guilty or has been found guilty of a contraband charge within the past five years (as defined in Subsection D of this regulation) for a subsequent offense shall have all visiting privileges suspended for a maximum of one year, excluding approved clergy, attorney visits and special visits.

c. Suspended visiting privileges cannot consist of more than two simultaneous suspensions (i.e., the original suspension and any subsequent suspension).

d. At the end of the suspension, the offender shall submit to the warden or designee a written request to have visitation reinstated and shall also submit a new request for changes to approved visiting list.

e. A review of the circumstances of the applicable contraband UOR(s) and the offender's current conduct record shall be conducted by an appropriate board at a minimum of every six months.

f. Restriction of no visiting is not a disciplinary penalty.

3. Suspension of a Visitor's Visiting Privileges

a. Any person may be refused approval to visit an offender and removed from an approved visiting list if the visitor does not comply with the rules of the institution. (Such removal may be temporary or permanent, depending upon the severity of the violation.)

b. Any person causing or participating in a disturbance or one that is disrespectful may be refused approval to visit an offender. If an offense is such that it is the warden or designee's desire to remove the visitor from the visitor list (either permanently or for a fixed period of time), the following procedures shall be followed.

i. The warden or designee shall notify the visitor in writing that he has been removed from all applicable visiting lists, the reason why and that the removal will be reviewed after a specified amount of time. The visitor shall also be notified in writing that he may appeal the warden's decision to the secretary by sending a letter within 15 days of the date of the notice.

ii. If the visitor exercises this appeal right, the secretary or designee shall review the appeal and investigate, as appropriate, within 30 days of notice. If necessary, a hearing shall be scheduled and the visitor shall be notified of the time, date and location of the hearing.

iii. The warden or designee may submit a report to the secretary setting forth any information that he feels may assist in making the decision. If a hearing is held, the secretary or designee may determine that the warden or designee should attend this hearing; in this case, the warden shall be so advised. Otherwise, the hearing shall consist of a meeting between the visitor and the secretary or designee and shall be preserved by minutes.

iv. The secretary shall render a written decision granting or denying the appeal and shall notify the visitor and the warden of the decision without undue delay. Brief reasons for the decision shall be given.

c. Reinstatement of visiting privileges for visitors who are removed for a fixed period of time may only be considered upon written request from the offender following the procedures detailed in Paragraph J.2 of this Section and only after the fixed period of time for the removal has elapsed. Should reinstatement be denied, the offender shall be notified in writing of the denial and that reconsideration will only be given at the next opportunity for changes to the offender's visiting list.

S. Guidelines for Visitors. Visitation with offenders committed to the Louisiana Department of Public Safety and Corrections (DPS and C) is a privilege. Visitation may be restricted, denied or suspended if an offender and/or visitor does not follow the department's visitation rules. Prospective visitors may refer to www.doc.louisiana.gov for the

department's regulation governing offender visitation. The regulation may also be obtained by requesting a copy from the facility. Items considered to be contraband, including any type of weapon, firearm, ammunition or any other item detrimental to the security of the facility are never allowed to be brought onto the grounds of a correctional facility. Some prohibited items and personal possessions (wallet, purse, cash, etc.) must be left in the visitor's locked vehicle for the duration of the visit. The following are rules that a visitor must follow in order to be allowed to visit with an offender.

1. Visiting List. In order to visit an offender, the visitor must be on the offender's approved visiting list. The offender has been given information on how to put someone on their visiting list. If you are uncertain as to whether you are on the offender's approved visiting list, please contact the offender you wish to visit. Do not call the facility for this information; it will not be provided over the phone.

2. Searches. All visitors, including minors, are subject to searches of their property, automobile and person. This is necessary to preclude the introduction of contraband into the prison environment. These searches shall be conducted by trained staff in a professional manner that minimizes indignity to the visitor while still accomplishing the objective of the search. Additionally, visitors shall be subject to additional searches using metal detectors and ion scanning equipment. Specially trained search dogs (K-9's) may be used as a part of the search process both prior to a visitor entering the visiting area and in the actual visiting room during visits. Any person refusing to be searched at any time shall not be permitted to enter the facility and a visit may be terminated if a visitor refuses to be searched, or if contraband or other prohibited property or items are found on the visitor or in the visitor's property. If a visitor does not wish to be searched either by hand or by using other means, the visitor should not attempt to enter a DPS and C facility.

3. Registration. Visitors must register with staff prior to entering the visiting area.

4. Identification. All visitors who are 18 years old or older shall be required to show a picture identification each time they visit. The forms of identification accepted by the DPS and C are:

- a. valid driver's license from the state of residence;
- b. valid state photo identification card from the state of residence;
- c. valid military photo identification card (active duty only);
- d. valid passport.

5. Children. Visitors under the age of 18 years of age must be accompanied by their parent or legal guardian at all times while on facility grounds. Children shall not be left alone at any time while on facility grounds. Parents or legal guardians shall be responsible for the behavior of their children and a visit may be terminated if the children become disruptive.

6. Dress Standards. Visitors shall wear clothing that poses no threat to the security or maintenance of order at the facility. The following standards are to be met.

a. Clothing that is similar in appearance to the clothing worn by the prison's offender population is prohibited.

b. Clothing that is similar in appearance to the clothing worn by correctional officers, i.e. camouflage, blue BDU's, etc. is prohibited.

c. Sheer or transparent clothing is not permitted.

d. Swim suits are not permitted.

e. Skirts, shorts, skorts, culottes and dresses must be no shorter than three inches above the kneecap and not have deep or revealing slits.

f. Strapless, tube and halter tops, tank tops and strapless dresses are not permitted.

g. Tops that expose the midriff are not permitted.

h. Tight fitting pants, such as stirrup, spandex, lycra or spandex-like athletic pants, aerobic/exercise tights or leotards shall not be worn.

i. Undergarments must be worn at all times and cannot be exposed.

j. Clothing with revealing holes or tears higher than one inch above the kneecap is not permitted.

k. Clothing or accessories with obscene or profane writing, images or pictures is not permitted.

l. Gang or club-related clothing or insignia indicative of gang affiliation is not permitted.

m. Shoes must be worn at all times, except for infants who are carried. House slippers or shower shoes are not allowed.

n. Hats or other head coverings are not permitted, except as required by religious beliefs.

7. Items not Permitted. Visitors shall not be permitted to possess or carry the following items into the visiting area:

a. any weapon, firearm, ammunition or any other item detrimental to the security of the facility;

b. cameras, video and audio recording equipment and electronic devices, including but not limited to cellular phone or component hardware or other electronic communications device, whether operational or not, (including but not limited to beepers, pagers, subscriber identity module (SIM) cards, portable memory chips, batteries for these devices, chargers or global satellite system equipment) etc.;

c. controlled substances or illegal drugs;

d. alcohol;

e. tobacco and tobacco related items.

8. Medication. Only prescribed medication that is life-saving or life-sustaining (such as nitroglycerine pills, inhalers, oxygen, etc.) shall be permitted. Medication shall be limited in quantity to no more than that required for the duration of the visit. Visitors must advise the staff at the visiting desk that they are in possession of such medication.

9. Infants. If the visitor has an infant child, the following items shall be permitted: four diapers; two jars vacuum sealed baby food; two plastic bottles milk or juice; one change of clothing; one baby blanket (maximum width and length not to exceed 48 inches) and one clear plastic bag of baby wipes. These items (except the baby blanket) must be stored in a single clear plastic container (i.e., gallon size zip-lock bag.) All items are subject to search.

10. Money. See www.doc.louisiana.gov for facility-specific limitations on the amount a visitor is permitted for vending machines and/or concessions. Visitors shall not give any money to an offender. Financial transactions for offenders shall be in the form of cash and/or credit or debit card payments made at the unit's visitor center kiosk

machines provided by the department's contractor for offender services for use by the offender's approved visitors. All other money from permissible sources may be accepted and processed in accordance with established procedures.

11. Contact between Offenders and Visitors. Offenders who have "contact" visits may embrace (hug) and exchange a brief kiss (briefly to indicate fondness, not a lingering kiss) with their visitor at beginning and end of the visit. During the visit, the only contact permitted is holding hands. Excessive displays of affection or sexual misconduct between offenders and visitors is strictly prohibited. Small children may be permitted to sit on the lap of the visitor or offender. Any improper contact between an offender and visitor shall be grounds for stopping the visit immediately. Some offenders are restricted to "non-contact" visits. In these cases, there shall be no physical contact (touching) between the offender and the visitors. Restroom breaks may be authorized; however, visitors will be subject to the entire search process.

12. Restrictions on Visits with Minors. Offenders who have a current or prior conviction for a sex crime involving a minor child family member, or who have a documented history of sex abuse with a minor child family member, are ineligible to visit with any minor child, including their own biological or step-child. Offenders who have a current or prior conviction for a sex crime involving a minor child who is not a family member are ineligible to visit with any minor child. The offenders affected by these restrictions have been informed of possible exceptions that may only be approved by the warden. See www.doc.louisiana.gov for additional information on restriction of visits with minors.

13. Court Ordered Visitation. Pursuant to the provisions of Act No. 383 of the 2014 Regular Session, a court may authorize visitation with an incarcerated parent. In cases of court ordered visitation, the department cannot deny the visit. However, such visitation shall be in conformance with all other rules and regulations that pertain to visiting.

14. Generally Prohibited. The giving or receiving of any item(s) to/from an offender without the prior approval of staff is prohibited. Violators are subject to arrest and criminal prosecution and suspension of visiting privileges either permanently or for a fixed period of time. The only exception is that the visitor may purchase soft drinks, snacks or concessions in the visiting area and share them with the offender. The offender is not permitted to take anything out of the visiting area when the visit is finished, other than with approval as noted above.

15. Visiting Hours. See www.doc.louisiana.gov for visiting hours at a specific facility.

16. Public Transportation. Some DPS and C facilities have public transportation available to the facility. Information is provided at the facility to the offender population if public transportation is available. There may be a cost for use of this transportation and the DPS and C does not endorse or claim any liability for the use of the transportation provider. The visitor may contact the offender they wish to visit to obtain specific information regarding any types of transportation that may be available to the facility where the offender is housed.

17. Directions. Driving directions may be found under the name of the facility the visitor wishes to visit at www.doc.louisiana.gov.

18. Termination of Visits. The warden of the facility or staff designated by the warden may terminate a visit at any time if they believe that ending the visit is in the best interest of the safety and security of the facility or the persons involved.

19. Other Specific Information Provided by the Offender or Facility. Other permissible items, special visit procedures and availability of picnic visits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:833(A).

HISTORICAL NOTE: Promulgated by the Department of Corrections, Office of Adult Services, LR 5:2 (January 1979), amended LR 11:1096 (November 1985), repromulgated LR 29:2851 (December 2003), amended by the Department of Public Safety and Corrections, Corrections Services, LR 32:406 (March 2006), LR 35:1248 (July 2009), LR 37:2177 (July 2011), LR 38:835 (March 2012), LR 41:1764 (September 2015).

James M. LeBlanc
Secretary

1509#037

RULE

Department of Public Safety and Corrections Office of State Police Transportation and Environmental Safety Section

Underground Utilities Committee
(LAC 55:I.2101)

The Department of Public Safety and Corrections, Office of State Police, in accordance with R.S. 49:950 et seq., and R.S. 40:1749.11 et seq., has amended its rules pertaining to underground utilities and facilities damage prevention by designating the membership of the Underground Utilities and Facilities Damage Prevention Advisory Committee.

Title 55

PUBLIC SAFETY

Part I. State Police

Chapter 21. Underground Utilities

§2101. Purpose

A. ...

B. The advisory committee referenced in Subsection A above is hereby established and shall be composed of the following members:

1. a representative of each certified Louisiana regional notification center;
2. a representative of the Department of Public Safety;
3. a representative of the Department of Environmental Quality;
4. a representative of the Right-to-Know Unit, Office of State Police;
5. a representative of the Department of Natural Resources, Pipeline Division;
6. a representative of the Office of the State Fire Marshal;
7. a representative of the Public Service Commission;
8. a representative of the Louisiana Chemical Association;
9. a representative of the Louisiana Gas Association;
10. a representative of the Louisiana Municipal Association;

11. a representative of the Louisiana Forestry Association;

12. a representative of the Louisiana Home Builders Association;

13. a representative of the Louisiana Rural Water Association;

14. a representative of the Louisiana Cable and Telecommunications Association;

15. a representative of the Louisiana Electric Cooperatives Association;

16. A representative of the Mid Continent Oil and Gas Association;

17. a representative of the Louisiana Farm Bureau Federation;

18. a representative of the Louisiana Associated General Contractors;

19. a representative of the Louisiana Common Ground Alliance;

20. a representative of offshore facility owners and operators.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1749.11 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 26:92 (January 2000), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, LR 41:1772 (September 2015).

Jill Boudreaux
Undersecretary

1509#011

RULE

Department of the Treasury Board of Trustees of the Louisiana State Employees' Retirement System

Election to the Board of Trustees
(LAC 58:I.405 and 407)

The Department of the Treasury, Board of Trustees of the Louisiana State Employees' Retirement System ("LASERS") has amended LAC 58:I.405 and 407. The Rule amendments facilitate which members are to receive an active member ballot and remove a redundancy, so that the single place for event dates is in the general schedule of elections set forth in §401. Further, these rule amendments clarify that the limit of two trustees per department within the executive branch of state government is limited to active trustees and excludes *ex officio* trustees.

Title 58

RETIREMENT

Part I. Louisiana State Employees' Retirement System Chapter 4. Rules Common to the Election of Both Active and Retired Member Trustees

§405. Election Process

[Formerly LAC 58:I.303.C-I and 503.C-J]

A. Active Members. Ballots or election brochures shall be distributed to each active member by the fourth Friday in September. This includes active members who are not deemed by LASERS to be retired before July 1 of the year in

which the election is to take place and participants in the DROP program who have not terminated service.

B. ...

C. There shall be a drawing as set forth in LAC 58:I.401 in the retirement systems building, 8401 United Plaza Boulevard, Baton Rouge, LA, to determine the position each candidate shall have on the ballot or election brochure.

D. - I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:511 and R.S. 11:515.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees of the State Employees' Retirement System, LR 22:373 (May 1996), amended LR 23:996, 997 (August 1997), LR 25:1278 (July 1999), LR 26:1490 (July 2000), LR 26:2633 (November 2000), LR 31:946, 947 (April 2005), LR 34:446, 447 (March 2008), LR 37:1616 (June 2011), LR 39:119 (January 2013), LR 41:1772 (September 2015).

§407. Winning Candidates
[Formerly LAC 58:I.303.B and G, 501.A and 503.H]

A.1. - B. ...

C. No department in the executive branch of state government may have more than two active trustees serving on the board at the same time. *Ex officio* trustees and their designees do not count toward this limit.

D. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:511 and R.S. 11:515.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees of the State Employees' Retirement System, LR 22:373 (May 1996), amended LR 23:996, 997 (August 1997), LR 25:1278 (July 1999), LR 26:1490 (July 2000), LR 26:2633 (November 2000), LR 31:946, 947 (April 2005), LR 34:446, 447 (March 2008), LR 37:1616 (June 2011), LR 39:119 (January 2013), LR 41:1773 (September 2015).

Cindy Rougeou
Executive Director

1509#026

RULE

Department of the Treasury
Louisiana Housing Corporation

Mortgage Credit Certificate Program
(LAC 16:II.Chapter 8)

Under the authority of R.S. 40:600.91(A)(3), and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Housing Corporation (LHC) has adopted the Louisiana Housing Corporation mortgage credit certificate (LHC MCC) Program. The program allows first time homebuyers to take a tax credit equal to the lesser of \$2,000 per year or 40 percent of their annual interest paid on their mortgage loan for their primary residence.

Title 16
COMMUNITY AFFAIRS
Part II. Housing Programs

Chapter 8. Mortgage Credit Certificate Program

§801. Introduction

A. The LHC MCC Program is designed to assist citizens of the state of Louisiana that:

1. are first time homebuyers or persons who have not owned a principal residence in the past three years;
2. are purchasing a residence in certain areas of the state, called "targeted areas;"
3. are using a 30-year fixed rate and term mortgage which does not involve mortgage revenue bonds; and
4. are purchasing a property to be used as their primary residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Louisiana Housing Corporation, LR 41:1773 (September 2015).

§803. Definitions

A. Notwithstanding the definitions set forth in the LAC 16:I.301, the following terms, when used in this Chapter, are defined as follows.

Annual Family Income—annual income from all sources before taxes or withholding of all members of the family living in the housing unit. Family annual income may not exceed 115 percent or less of the applicable median family income except in the case of a targeted area residence, in which instance the family annual income may not exceed 140 percent or less of the applicable family income.

Borrower(s)—an individual or family applying to receive mortgage funding under the LHC MCC Program.

Eligible Property—single family residence, planned unit development, condominium, or manufactured housing on a permanent foundation which is owned or being purchased and qualifying as real estate.

Housing Unit—living accommodations intended for occupancy by a single family, consisting of one unit, and which will be owned by the occupant thereof; or, one unit principal residences that are detached structures, condominiums, townhomes or planned unit development subject to Fannie Mae/Freddie Mac guidelines.

Program Type—FHA, VA, Rural Development, Fannie Mae or Freddie Mac Programs. Fixed rate and 30-year term required.

Purchase Price Requirements—the acquisition cost of the principle residence may not exceed 90 percent of the average area purchase price except in the case of a targeted area residence wherein the acquisition cost may not exceed 110 percent of the average area purchase price.

Targeted Area—that part of the eligible loan area that has been designated as a qualified census tract or an area of chronic economic distress in accordance with section 143(j)(3) of the *Internal Revenue Code* or as a qualified census tract in accordance with section 143(i)(2) of the *Internal Revenue Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Louisiana Housing Corporation, LR 41:1773 (September 2015).

§805. Eligible Borrowers

A. Borrowers will be determined to be eligible to participate in the LHC MCC Program if they meet the following criteria.

1. The borrower is a first time home buyer or has not owned a principal residence in the past three years, or is purchasing in a targeted area.

2. Household annual income does not exceed established income limits.

3. Borrower will occupy the property as his or her primary residence.

4. Borrower is using a fixed rate, 30-year mortgage that is not financed through the use of a mortgage revenue bond.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Louisiana Housing Corporation, LR 41:1773 (September 2015).

§807. Processing Qualifications of Borrowers Applications

A. An application for a LHC MCC shall be processed by the Louisiana Housing Corporation. Borrowers may apply through any LHC approved lender. The lending institution shall undertake its own due diligence and other matters as may be determined to be appropriate to insure that the proposed loan and mortgage credit certificate is consistent in all aspects of the Louisiana Housing Corporation's evaluation factors. The Louisiana Housing Corporation will also underwrite the application.

B. Borrowers who obtain an LHC MCC can still claim 60 percent of their total year mortgage interest as a tax deduction. LHC MCC will allow homebuyers to convert 40 percent of their mortgage interest deduction to a life of loan tax credit, not to exceed \$2,000 per year. The tax credit is available each year for the life of the original loan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Louisiana Housing Corporation, LR 41:1774 (September 2015).

§811. Types of Assistance and Proscribed Use

A. Borrowers will pay a 1 percent origination fee to the LHC for the issuance of an LHC MCC and a \$75 compliance fee.

B. Lenders will be allowed to charge up to \$500 per MCC application.

C. Maximum loan amount is based upon applicable program guidelines (i.e. conventional, FHA, VA or rural development).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Louisiana Housing Corporation, LR 41:1774 (September 2015).

Michelle L. Thomas
Appointing Authority

1509#004

RULE

**Workforce Commission
Office of Workers' Compensation Administration**

**Outlier Reimbursement and Appeals Procedures
(LAC 40:I.2519)**

Editor's Note: This Rule is being repromulgated to correct a typographical error. The previous Fiscal and Economic Impact Statement stated the need to replace code 949 with more

specialized codes. The now stricken code was accidentally left in for May final Rule publication.

This Rule is promulgated by the authority vested in the director of the Office of Workers' Compensation found in R.S. 23:1310(C). It has enacted corrections to Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapter 25, Section 2519, Outlier Reimbursement and Appeals Procedures.

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Subpart 2. Medical Guidelines

Chapter 25. Hospital Reimbursement Schedule, Billing Instruction and Maintenance Procedures

§2519. Outlier Reimbursement and Appeals Procedures

A. Automatic Outliers. Inpatient hospital acute care services falling within certain diagnosis code ranges will be reimbursed outside the normal per diem reimbursement method. These atypical admissions will be paid at covered billed charges less a 15 percent discount. Conditions requiring acute care inpatient hospital services that are work-related and are recognized as "automatic outliers" are:

1. AIDS: ICD-9 Diagnosis Codes 042-044;

2. Acute Myocardial Infarction: ICD-9 Diagnosis Code 410; and

3. Severe Burns: ICD-9 Diagnosis Codes: 940.0-940.9; 941.30-941.39; 941.40-941.49; 941.50-941.59; 942.30-942.39; 942.40-942.49; 942.50-942.59; 943.30-943.39; 943.40-943.49; 943.50-943.59; 944.30-944.39; 944.40-944.49; 944.50-944.59; 945.30-945.39; 945.40-945.49; 945.50-945.59; 946.3; 946.4; 946.5; 947.0-947.9; 948.00 ; 948.10; 948.11; 948.20-948.22; 948.30-948.33; 948.40-948.44; 948.50-948.55; 948.60-948.66; 948.70-948.77; 948.80-948.88; 948.90-948.99; 949.3; 949.4; 949.5.

B. - B.7.a. ...

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:981 (May 2015), repromulgated LR 41:1774 (September 2015).

Curt Eysink
Executive Director

1509#005

RULE

**Workforce Commission
Rehabilitation Services**

Vocational Rehabilitation Program (LAC 67:VII.Chapter 1)

In accordance with the provisions of R.S. 49:953(B) of the Administrative Procedure Act, Louisiana Workforce Commission, Louisiana Rehabilitation Services (LRS) has amended §103, §105, §115, §117, and §119 of its Vocational Rehabilitation Program (VR) policy manual to provide

clarification of processes and to update guidelines to be used in the determination of financial assistance for eligible consumers. In §103, Enabling Legislation, Louisiana Rehabilitation Services updated its policy manual to reflect the agency transfer to the Louisiana Workforce Commission from the Department of Social Services per Act 939 of the 2010 Legislative Session. In §105, Confidentiality, the agency clarified the need to have written consent to release an individual's case file information. In §115, Financial, the agency removed the out-of-date basic living requirement chart and will utilize a multiple of 250 percent of the U.S. Department of Health and Human Services' poverty guidelines, which is updated annually, thus allowing the agency access to the most up-to-date information when determining financial assistance for eligible consumers. In §117, Vocational Rehabilitation Services, the agency restructured policy pertaining to the scope of establishing a small business. The agency revised the definition of "transition student" in §119, Transition Process for Individuals in Secondary Education Programs.

Title 67

SOCIAL SERVICES

Part VII. Rehabilitation Services

Chapter 1. General Provisions

§103. Enabling Legislation

A. - B. ...

C. *Louisiana Revised Statutes*

1. Act 939 of the 2010 Legislative Session transferred programs operated by LRS from the Department of Social Services to Louisiana Workforce Commission.

2. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23-3001.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 17:891 (September 1991), amended LR 20:317 (March 1994), LR 25:1265 (July 1999), LR 29:46 (January 2003), amended by Workforce Commission, Rehabilitation Services, LR 41:1775 (September 2015).

§105. Confidentiality

A. - B.5. ...

C. Release of Confidential Information

1. The case file must contain documentation concerning any information released with the individual's written consent. Informed written consent is required for the release of personal records to the following:

a. public assistance agencies or programs from which the client has requested services or to which the client is being referred for services;

b. the Louisiana Workforce Commission, formerly the Louisiana Department of Labor, and military services of the United States government;

c. doctors, hospitals, clinics, rehabilitation centers, community rehabilitation programs and vendors providing services to clients as authorized by Louisiana Rehabilitation Services;

d. schools or training centers, when LRS has authorized the service or is considering authorizing such services, and the information is required for the client's success in the program, for the safety of the client, or is otherwise in the client's best interest.

2. - 2.c. ...

3. LRS may also release personal information to protect the individual or others when the individual poses a threat to his/her safety or the safety of others.

D. - G.2.b. ...

c. inform the regional manager or designee if the above steps do not resolve the situation. In this case, the regional manager or designee will then turn the matter over to the Louisiana Workforce Commission's legal counsel.

3. - 3.d.iii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23-3001.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 17:891 (September 1991), amended LR 20:317 (March 1994), LR 22:993 (October 1996), repromulgated LR 25:1265 (July 1999), amended by the Workforce Commission, Rehabilitation Services, LR 41:1775 (September 2015).

§115. Financial

A. - B.2.a.vii. ...

viii. on-the-job training;

ix. assistive technology devices and services (except hearing aids);

x. personal assistance services provided simultaneously with any of the above-listed vocational rehabilitation services; (Examples include attendant, reader, scribe, interpreter, ASL, braille, notetaker, and adjustment/orientation and mobility training services.)

2.b. - 3.d.ii. ...

C. LRS shall determine an individual's financial need for certain vocational rehabilitation services based on the individual's disability related expenses, available assets, and a multiple of 250 percent of the current U.S. Department of Health and Human Services' poverty guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23-3001.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 17:891 (September 1991), amended LR 20:317 (March 1994), LR 21:837 (August 1995), LR 24:959 (May 1998), LR 25:1273 (July 1999), LR 27:212 (February 2001), LR 27:1561 (September 2001), LR 29:47 (January 2003), LR 30:1488 (July 2004), LR 34:1038 (June 2008), amended by the Workforce Commission, Rehabilitation Services, LR 41:1775 (September 2015).

§117. Vocational Rehabilitation Services

A. - C.1.b.ii. ...

D. Scope of Establishment of Small Business Enterprise

1. The purpose of a self-employment goal for a client is to establish an individual with a disability in a small business enterprise that will provide sufficient income to support the individual and their family, thereby enabling the individual to meet ordinary daily living expenses and business costs. LRS desires to make self-employment an available option only when it is clearly demonstrated that self-employment is the best choice for the client.

2. All other applicable state, federal, and agency laws, policy and procedure must be followed, including state purchasing laws.

3. These policy provisions do not apply to the Randolph Sheppard Program.

4. Ultimate approval of funding a small business enterprise for an eligible vocational rehabilitation client lies with Louisiana Rehabilitation Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23-3001.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:891 (September 1991), amended LR 20:317 (March 1994), LR 25:1274 (July 1999), amended by the Workforce Commission, Rehabilitation Services, LR 41:1775 (September 2015).

§119. Transition Process for Individuals in Secondary Education Programs

A. - D. ...

E. The following provisions are the key points in LRS' transition process:

1. LRS will provide consultation and technical assistance (to the extent possible considering time and agency resources) as early as possible in the transition process, for students with disabilities who have an individualized education plan (IEP), have been under section 504 of the Rehabilitation Act, or is an individual with a disability under the Rehabilitation Act.

2. LRS will ensure the development and approval of IPEs for eligible students as early as possible in the transition process but, at the latest, by the time each student determined eligible for vocational rehabilitation services leaves the school setting.

F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23-3001.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 17:891 (September 1991), amended LR 20:317 (March 1994), repromulgated LR 25:1276 (July 1999), amended LR 30:1488 (July 2004), amended by the Workforce Commission, Rehabilitation Services, LR 41:1776 (September 2015).

Curt Eysink
Executive Director

1509#051

Notices of Intent

NOTICE OF INTENT

Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences

Horticulture and Quarantine Programs
Emerald Ash Borer Quarantine (LAC 7:XV.167)

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and pursuant to the authority set forth in R.S. 3:1652, notice is hereby given that the Department of Agriculture and Forestry (“department”) intends to adopt the Rule set forth below, establishing a quarantine for the following pest: emerald ash borer (“EAB”), *Agrius planipennis* fairmaire. The state entomologist has determined that EAB has been found in this state and may be prevented, controlled, or eradicated by quarantine. This quarantine was first established by Emergency Rule published at LR 41:885, Vol. 5.

EAB poses an imminent peril to the health and welfare of Louisiana forests, commercial and private forestry/wood product industries, and nursery growers due to its ability to infest ash trees. In 2013, the wholesale value of woody ornamental sales for nursery growers in the state was \$62.6 million, a portion of which is comprised of sales of ash trees (Louisiana State University AgCenter 2013 Louisiana Summary, Agriculture and Natural Resources). Louisiana’s forests and forestry/wood products industries generated an output industry production value of \$10.86 billion in 2012, a portion of which is comprised of ash trees and ash tree products (Louisiana State University AgCenter publication 3367-G, 2015). Sales of ash firewood by retail and wholesale suppliers to private individuals also are important to the state’s economy.

Natural spread of EAB is limited to relatively short distances. However, without restriction, EAB can spread through human-assisted means over long distances via infested ash nursery stock, ash logs/timber and cut firewood. Once an ash tree is infested, it experiences twig dieback and tree decline. Tree death occurs within a few years. Failure to prevent, control, or eradicate this pest threatens to damage Louisiana’s commercial ash tree nursery industry, and over time this pest poses a threat to destroy the majority of ash in our state, both commercial and residential. The loss of the state’s commercial nursery-grown ash trees, forestry/wood ash products and even residential ash trees would be devastating to the state’s economy and to its private citizens. The quarantine established by this emergency regulation is necessary to prevent the spread of EAB to all areas in Louisiana where ash may exist, outside of the current areas where this pest has been found.

For these reasons, the presence of EAB in Louisiana presents an imminent peril to the health, safety and welfare of Louisiana’s citizens and forests, the state’s commercial and private forestry/wood product industries, and nursery growers. As a result of this imminent peril, the Department of Agriculture and Forestry, Office of Forestry and Office of

Agricultural and Environmental Sciences, hereby exercises its full and plenary power pursuant to R.S. 3:1652 to deal with crop and fruit pests and contagious and infectious crop and fruit diseases by imposing the quarantines set out in the regulations proposed herein.

Title 7

AGRICULTURE AND ANIMALS

Part XV. Plant Protection and Quarantine

Chapter 1. Crop Pests and Diseases

Subchapter F. Emerald Ash Borer Quarantine

§167. Emerald Ash Borer Quarantine

A. The department issues the following quarantine because the state entomologist has determined that the insect emerald ash borer (“EAB”), *Agrius planipennis*, has been found in this state and may be prevented, controlled, or eradicated by quarantine.

B. Quarantined areas in this state include:

1. the entire parishes of Bossier, Claiborne and Webster;

2. a declaration of quarantine for EAB covering any other specific parishes or areas of this state shall be published in the official journal of the state and in the *Louisiana Register*.

C. No regulated articles as defined in this Section shall be moved out of any area of this state that is listed in this Section as a quarantined area for EAB, except as provided in this Section.

D. The following articles are hosts of EAB and are deemed to be regulated articles for purposes of this Subsection:

1. the emerald ash borer in all of its life stages; firewood of all hardwood (non-coniferous) species; nursery stock, green lumber, and other material living, dead, cut, or fallen, including logs, stumps, roots, branches, and composted and uncomposted chips of the genus *Fraxinus*;

2. any other article, product, or means of conveyance not listed in this Section may be designated as a regulated article if an inspector determines that it presents a risk of spreading emerald ash borer and notifies the person in possession of the article, product, or means of conveyance that it is subject to the restrictions of the regulations.

E. Regulated articles may be moved from quarantined areas to non-quarantined areas within or outside of Louisiana only if moved under the following conditions.

1. The regulated articles being moved are accompanied by a certificate or limited permit issued by LDAF and attached in accordance with the EAB federal requirements.

2. The regulated articles being moved are not accompanied by a certificate or limited permit but are being moved by the United States Department of Agriculture for experimental or scientific purposes.

3. The regulated articles being moved are not accompanied by a certificate or limited permit but originated outside of any EAB quarantined area and are moved interstate through the quarantined area under the following conditions:

a. the points of origin and destination are indicated on a waybill accompanying the regulated article; and

b. the regulated article, if moved through the quarantined area, is moved in an enclosed vehicle or is completely covered to prevent access by the EAB; and

c. the regulated article is moved directly through the quarantined area without stopping (except for refueling or for traffic conditions, such as traffic lights or stop signs), or has been stored, packed, or handled at locations approved by an inspector as not posing a risk of infestation by emerald ash borer; and

d. the article has not been combined or commingled with other articles so as to lose its individual identity.

F. Persons or businesses engaged in growing, handling, or moving regulated articles intrastate may enter into a compliance agreement with LDAF if such persons or businesses review with an LDAF inspector each provision of the compliance agreement. Any person or business who enters into a compliance agreement with LDAF must agree to comply with the provisions of this Subpart and any conditions imposed under this Subpart.

1. Any compliance agreement may be canceled orally or in writing by an inspector whenever the inspector determines that the person who has entered into the compliance agreement has not complied with this Subpart or any conditions imposed under this Subpart. If the cancellation is oral, the cancellation will become effective immediately, and the cancellation and the reasons for the cancellation will be confirmed in writing as soon as circumstances permit. Any person whose compliance agreement has been canceled may appeal the decision in writing to LDAF within 10 days after receiving the written cancellation notice. The appeal must state all of the facts and reasons that the person wants LDAF to consider in deciding the appeal. A hearing may be held to resolve a conflict as to any material fact. Rules of practice for the hearing will be adopted by LDAF. As soon as practicable, LDAF will grant or deny the appeal, in writing, stating the reasons for the decision.

G. Any person violating this quarantine shall be subject to imposition of the remedies and penalties set forth in R.S. 3:1653.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1652, 3:1653.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, LR 41:

Family Impact Statement

The proposed Rule does not have any known or foreseeable impact on family formation, stability, and autonomy. In particular, the proposed Rule has no known or foreseeable impact on:

1. the stability of the family;
2. the authority and rights of persons regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children;
6. the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule does not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed Rule does not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments, data, opinions and arguments regarding the proposed Rule. Written submissions must be directed to Tad Hardy, Director of the Horticulture Commission, Department of Agriculture and Forestry, 5825 Florida Blvd., Suite 3002, Baton Rouge, LA 70806 and must be received no later than 4 p.m. on November 4, 2015. No preamble is available.

Mike Strain, DVM
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Horticulture and Quarantine Programs Emerald Ash Borer Quarantine

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule will have not a fiscal impact to the state other than the cost of promulgation for FY 16. Existing LDAF personnel in Bossier, Claiborne, and Webster Parishes will carry out additional inspection duties as a result of the proposed rule. The proposed rule places a quarantine on regulated articles which are susceptible of infestation by the emerald ash borer ("EAB"), *Agilus planipennis* Fairmaire.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule will not have an effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Any entities with regulated articles in the quarantined areas will not be permitted to move those regulated articles from

quarantined areas to non-quarantined areas without a certificate or limited permit issued by the department. The only stoppages entities moving regulated articles will be able to make while moving regulated articles from non-quarantined areas will be for traffic conditions and fueling stops.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule is not anticipated to have an effect on competition and employment.

Dane Morgan
Assistant Commissioner
1509#058

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Licensure or Permitting Fees (LAC 7:XXIX.109)

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Department of Agriculture and Forestry (“department”) intends to amend LAC 7:XXIX.109 regarding fees for licensure and permitting. Act 202 of the 2015 Regular Session amended R.S. 3:3806 and set forth ranges which the department may charge for the issuance or renewal of certain licenses and permits. The proposed Rule sets the fee for applicable licenses and permits within the ranges set by Act 202. The proposed Rule raises fees for the issuance or renewal of a license as an arborist, landscape horticulturist, landscape irrigation contractor, landscape architect, retail florist, utility arborist, or wholesale florist from \$75 to \$100, increases the fee for issuance or renewal of a nursery stock dealer permit from \$130 to \$150, and increases the fee for issuance or renewal of a cut flower dealer permit from \$70 to \$90. The proposed Rule also provides for a \$25 late fee to be charged after the fifteenth working day after a license or permit has expired. The late fee is also authorized by R.S. 3:3806 and is not a change in the law.

Title 7

AGRICULTURE AND ANIMALS

Part XXIX. Horticulture Commission

Chapter 1. Horticulture

§109. Examination and Licensure or Permitting Fees

A. - A.2. ...

B. Arborist, Landscape Horticulturist, Landscape Irrigation Contractor, Retail Florist, Utility Arborist, Wholesale Florist

1. ...

2. The fee for issuance or renewal for licensure as an arborist, landscape horticulturist, landscape irrigation contractor, landscape architect, retail florist, utility arborist, or wholesale florist shall be \$100.

3. The fee for issuance or renewal of a nursery stock dealer permit shall be \$150.

4. The fee for issuance or renewal of a cut flower dealer permit shall be \$90.

C. A late fee of \$25 shall be charged after the fifteenth working day after a license or permit has expired for the renewal thereof

D. All fees required under this rule must be submitted at the same time as the application; failure to submit any required fees will bar the applicant from taking the examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3806, R.S. 3:3805, and R.S. 3:3801.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Horticulture Commission, LR 8:184 (April 1982), amended by the Department of Agriculture and Forestry, Horticulture Commission, LR 14:8 (January 1988), LR 18:249 (March 1992), LR 20:640 (June 1994), LR 29:2297 (November 2003), LR 31:1053 (May 2005), LR 35:1227 (July 2009), LR 37:3464 (December 2011), LR 40:758 (April 2014), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Horticulture Commission, LR 41:

Family Impact Statement

The proposed Rule does not have any known or foreseeable impact on family formation, stability, and autonomy. In particular, the proposed Rule has no known or foreseeable impact on:

1. the stability of the family;
2. the authority and rights of persons regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children;
6. the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule does not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed Rule does not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments, data, opinions and arguments regarding the proposed Rule. Written submissions must be directed to Tad Hardy, Director

of the Horticulture Commission, Department of Agriculture and Forestry, 5825 Florida Blvd., Suite 3002, Baton Rouge, LA 70806 and must be received no later than 4 p.m. on November 4, 2015. No preamble is available.

Mike Strain, DVM
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Licensure or Permitting Fees

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule will have no associated costs or savings to the state other than the cost of promulgation for FY 16. The proposed rule raises fees for the issuance or renewal of professional licenses for arborists, landscape horticulturists, landscape irrigation contractors, landscape architects, retail florists, utility arborists, and wholesale florists from \$75 to \$100; increases the fee for issuance or renewal of a nursery stock dealer permit from \$130 to \$150; and increases the fee for issuance or renewal of a cut flower dealer permit from \$70 to \$90. The horticulture commission has the authority under R.S. 3:3806 to set the fees for all professions provided the fees remain within the range of fees set forth in the statute. Act 202 of 2015 increases the fee ranges chargeable by the Horticulture Commission for professional licenses from \$75 to \$150, for nursery stock dealer licenses from \$130 to \$175, and for cut flower dealer permits from \$70 to \$140. The proposed rule does not raise fees to the maximum allowed by Act 202 of 2015.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

LDAF anticipates the proposed rule change will generate an additional \$195,670 in a full fiscal year for the department to the extent license issuances and renewals continue based upon historical averages. For reference, LDAF annually issues an average of 5,822 horticulture professional licenses, 1,459 nursery stock dealer permits, and 1,047 cut flower dealer permits annually. The revenue generated in FY 16 will be less since the rule will only be in place for part of the fiscal year due to legal delays associated with rulemaking under the Administrative Procedure Act. Based upon prior activity, the fee increases are anticipated to approximately generate an additional \$114,000 in FY 16. The increased revenue will allow the department to fully fund expenditures necessary for regulating industries under the authority of Horticulture Commission, as well as the administrative work and costs associated with issuing licenses and permits. The increased revenues will be deposited into the Horticulture & Quarantine Fund.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule will affect those individuals or businesses applying for a license or permit in an industry regulated by the department and/or horticulture commission by requiring them to pay a higher fee. It is not anticipated that the proposed rule will result in an increase in paperwork or workload for any affected person or group. The proposed rule will require anyone applying for the issuance or renewal of a license as an arborist, landscape horticulturist, landscape irrigation contractor, landscape architect, retail florist, utility arborist, or wholesale florist to pay a fee of \$100. This is an increase of \$25 from the current license fee of \$75. The proposed rule increases the fee for issuance or renewal of a nursery stock dealer permit from \$130 to \$150. The proposed

rule increases the fee for issuance or renewal of a cut flower dealer permit from \$70 to \$90.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

Dane Morgan
Assistant Commissioner
1509#059

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Culture, Recreation and Tourism
Office of Tourism**

Welcome Centers (LAC 25:V.505)

The Louisiana Department of Culture, Recreation and Tourism, Office of Tourism, in accordance with R.S. 51:1255 and the Administrative Procedure Act, R.S. 49:950 et seq., hereby provides notice of its intent to amend LAC 25:V:505 to increase and streamline the standard fees for the reserved exclusive use of welcome centers.

**Title 25
CULTURAL RESOURCES
Part V. Office of Tourism**

Chapter 5. Welcome Centers

§505. Standard Fees

A. Standard fees for reserved exclusive use of the Capitol Park Welcome Center shall be assessed as follows.

Space	Capacity	Full Day Rate (3 hours or more)	Half Day Rate (less than 3 hours)	Evening (after 5:00 pm) and Weekend Rate
Entire Building and Patio	350 seated; 600 reception	\$1000	\$600	\$1900.00 (3 hour minimum) \$500.00/ additional hour
Margaret Taylor Theater includes Audio/Visual Capabilities	100 seated (lecture) 80 seated (classroom) 200 reception	\$500	\$300	Unavailable separately for evening or weekend use.
Fishbowl "Glass Room" (no audio/visual)	65 seated (lecture)	\$300	\$200	Unavailable separately for evening or weekend use.

B. - B.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1255.

HISTORICAL NOTE: Promulgated by the Department of Culture, Recreation and Tourism, Office of Tourism, LR 36:50 (January 2010), amended LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this

proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Statement

In compliance with R.S. 49:965.6, a regulatory flexibility analysis of the impact of this Rule on small businesses has been conducted. It is anticipated that this proposed Rule will have no impact on requirements imposed upon small businesses as described in R.S. 49:965.6.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, the total direct and indirect effect on the cost to the provider to provide the same level of service, and will not impact the ability of the provider to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Nancy N. Broussard, Welcome Center Program Director, Office of Tourism, P.O. Box 94291, Baton Rouge, LA 70804-9491. All comments must be received by 4:30 p.m. on October 10, 2015.

Kyle Edmiston
Assistant Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Welcome Centers**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no anticipated implementation costs or savings to state or local governmental units as a result of the proposed rule change. The proposed rule change modifies the rental fee schedule for the Capitol Park Welcome Center.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will increase fees and simplify the fee schedule for the Capitol Park Welcome Center. The increase in fees is anticipated to generate an additional \$10,000 in revenue annually. The largest increase in revenue will come from the changes made to fees associated with renting the entire facility. The rental rates will increase from \$500 to \$600 per hour for rentals under 3 hours, while rentals over 3 hours will increase from \$600 to \$1,000 per hour. The evening and weekend rental rate will also increase from \$550 per hour to \$1,900 for a 3-hour minimum and \$500 for every additional hour thereafter. Fees for the Margaret Taylor Theater will increase from \$425 per hour to \$500 per hour for events lasting longer than 3 hours and increase from \$275 to \$300 per hour for events under 3 hours. The Fishbowl, a glass room meeting space, will increase from \$175 to \$300 per hour for events over 3 hours and \$125 to \$200 per hour for events under 3 hours. The Margaret Taylor Theater and Fishbowl are not available to rent separately during evenings and weekends.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The fee increases in the proposed rule change will likely increase costs to persons and non-governmental entities that use the facilities.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated impact on competition or employment. The Office of Tourism surveyed the rental rates of other popular downtown venues and determined even after the increases the Welcome Center would still have the lowest rental fees of any facilities in the area.

Kyle Edmiston
Assistant Secretary
1509#035

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Economic Development
Office of Business Development**

Angel Investor Tax Credit (LAC 13:I.3307 and 3309)

Under the authority of R.S. 47:6020 and R.S. 36:104, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Economic Development proposes to amend and reenact LAC 13:I.3307 and adopt section 3309 relative to the administration of the angel investor tax credit program. The proposed regulation aligns the rules with 2015 legislative changes and addresses the proof of investment period.

Title 13

ECONOMIC DEVELOPMENT

Part I. Financial Incentive Programs

Chapter 33. Angel Investor Tax Credit

§3307. The Amount, Allocation and Limitations of the Angel Investor Tax Credits

A. The following rules shall be applicable to investments by accredited investors in Louisiana entrepreneurial businesses.

1. For calendar year 2011, the department will begin accepting applications on September 1 and for all other calendar years, the department will begin accepting applications on January 1. The allocation of credits for all years will be administered on a first come, first serve basis until the annual \$5 million cap has been reached. However, on the day that the cap is reached, all applications received that day will be treated as received at the same time and the credits remaining for allocation that day will be prorated.

a. Upon receipt of an application for the reservation of credits, the department will send the business a reservation letter indicating the dollar amount of credits which their investors are entitled to receive if proof of investment can be shown.

b. Each business applicant will have to decide on their application if they are willing to accept a prorated credit amount should their application be received on the day the cap is reached. The business will also have to determine what percentage of proration they will accept. If the business

does not indicate in their application a willingness to accept a prorated credit amount at the percentage of proration available on the day the cap is reached, their application will be deemed to have been received the day following the day in which the cap was reached.

c. Proof of investment must be provided to the department within 120 days from the date of the reservation letter. The department will accept the subscription agreement as required by the Securities and Exchange Commission as proof of investment.

d. If proof of investment is made within the requisite 120 day period, the department will issue a tax credit certification letter to the investor.

i. The tax credit certification letter will include the investor's name, address, Louisiana taxpayer identification number and the amount of the credit. The tax credit certification letter will include a breakdown of which years and in what amounts per year the credit will be claimed.

ii. The Louisiana Department of Revenue will receive a copy of the tax credit certification letter for purposes of verification of the credits.

e. If proof of investment is not provided to the Department within the requisite 120 day period, the angel investor tax credits which had been reserved for that company's investors will be added to the remaining available annual credit cap.

f.i. Any returned reservation credits whose businesses could not provide proof of investment within 120 days, will be allocated when available on a first come, first serve basis until the annual \$5 million cap has been reached. However, on the day that the cap is reached, all applications received that day will be treated as received at the same time and the credits remaining for allocation that day will be prorated. Returned reservation credits will be made available the sooner of

(a). the day returned reservation credits exceed the amount of credits requested in applications in line to receive credits the next day or

(b). the day all 120 day proof of investment periods have expired.

ii. The timeline for proof of investment will be the same 120 day period as mentioned above.

g. A business who fails to provide proof of investment within 120 days will not be allowed to apply for angel investor credits again for a three month period. The three month period will begin on the day following the end of the 120 day period for proof of investment.

B. All applications for the reservation of credits shall be made on a form prescribed by the department. All applications for the reservation of credits shall be submitted to the department electronically to an email address specified by the department on its website. An application fee shall be submitted with all applications for reservation of credits. The application fee shall be equal to 0.5 percent (0.005) times the total anticipated tax incentive for the investors with a minimum application fee of \$500 and a maximum application fee of \$15,000, payable to Louisiana Department of Economic Development.

C. An investment earns tax credits in the calendar year in which the investment is made. The request for the

reservation of credits for an investment must be made in the same year in which the investment is made. In order to earn credits under this program, an investment can be made no earlier than 30 days prior to the reservation of credits.

D. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6020 and R.S. 36:104.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 32:229 (February 2006), amended LR 32:1595 (September 2006), amended by Department of Economic Development, Office of the Secretary, LR 37:3196 (December 2011), LR 41:

§3309. Applicability of Act 125 of the 2015 Legislative Session to the Angel Investor Tax Credits

A. Act 125 of the 2015 Regular Session of the Louisiana Legislature makes the following changes to the Angel Investor Tax Credits from July 1, 2015 until June 30, 2018:

1. Credits shall be reserved and issued at a rate of 25.2 percent of the investment amount in the LEB and credits shall be issued at the reserved rate regardless of the date of issuance;

2. The total amount of credits that may be reserved and issued in a calendar year is \$3.6 million, exclusive of any un-granted credits carried forward from previous years; and

3. An investor may be issued credits on investments up to \$720,000 per business per year and up to \$1.44 million total per business.

B. The provisions of this section shall supercede any contradictory provisions under this Chapter between July 1, 2015 and June 30, 2018.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6020 and R.S. 36:104.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 32:229 (December 2015), LR 41:

Provider Impact Statement

The proposed rulemaking should have no provider impact as described in HCR 170 of 2014.

Family Impact Statement

The proposed Rule changes have no impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Public Comments

Interested persons may submit written comments to Danielle Clapinski, Louisiana Department of Economic Development, P.O. Box 94185, Baton Rouge, LA 70804-9185; or physically delivered to Capitol Annex Building, Office of the Secretary, Second Floor, 1051 North Third Street, Baton Rouge, LA, 70802. Comments may also be sent by email to danielle.clapinski@la.gov. All comments must be received no later than 5 p.m., on October 26, 2015.

Public Hearing

A public hearing to receive comments on the Notice of Intent will be held on October 26, 2015 at 11 a.m. at the Department of Economic Development, 1051 North Third Street, Baton Rouge, LA 70802.

Anne G. Villa
Undersecretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Angel Investor Tax Credit

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will be no incremental costs or savings to state or local governmental units due to the implementation of the proposed rules. The Department of Economic Development intends to administer the program with existing personnel.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Acts 125 and 361 of the 2015 legislative session amended the Angel Investor Tax Credit Program. Act 125 lowers the annual cap for the Angel Investor tax credit program from \$5 million annually to \$3.6 million annually, lowers the investment cap to \$720,000 per year per investor and \$1.44M total per investor and decreases credit rates from 35% to 25.2% from July 1, 2015 until June 30, 2018. This legislative change results in a net revenue increase to the state general fund of \$450,000 annually in FY 16, FY17, and FY18. Though not addressed in the proposed rule, the legislation allows for a refund of the difference between old program provision and new provisions for those returns filing for an extension prior to July 1, 2015, which will slightly reduce the impact on the general fund. Act 361 provided for a new fee schedule for LED. Under the new fee schedule, the Angel Investor Tax Credit Program will receive increased application fees equaling \$43,000 in agency self-generated revenues for FY 16 – FY 18. The addition of both of these revenue increases results in a net revenue increase to the state of \$roughly \$500,000 annually for FY 16 – FY 18. In addition, increasing the time deadline from 60 days to 120 days for the investment to materialize may result in a higher credit utilization, though that amount is not quantified in this analysis.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The income of angel investors participating in the program will decrease by the increase in state general fund as fewer credits are anticipated to be paid out due to the legislation. In addition, the income of applicants will decrease slightly by the amount of the application fee they will now owe at the time of reservation of credits.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies receiving benefits under this program will gain competitively over companies that do not receive the program's benefits. While employment may increase in participating businesses, employment may be lessened in other competing businesses that do not participate in the program.

Anne G. Villa
Undersecretary
1509#050

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Economic Development
Office of the Secretary**

**Research and Development Tax Credit Program
(LAC 13:I.2904, 2905 and 2915)**

Under the authority of R.S. 47:6015 and R.S. 36:104, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Economic Development proposes to amend its rules.

The purpose of this regulation is to adopt legislative changes to the research and development tax credit program under R.S. 47:6015 as enacted by Acts 133, 361, and 412 of the 2015 Regular Session of the Legislature. The regulation amends the application fee amount, changes the credit from a refundable credit to a nonrefundable credit with a 5 year carry forward period and also clarifies LED will select and engage the CPA for any expense verification reports required of an applicant in the research and development tax credit program.

Title 13

ECONOMIC DEVELOPMENT

Part I. Financial Incentive Programs

Chapter 29. Research and Development Tax Credit

§2904. Type, Amount and Duration of Credit

A. Type. Any taxpayer meeting the following criteria shall be allowed a tax credit to be applied against income and corporation franchise taxes due:

A.1. - C.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6015.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 36:1768 (August 2010), amended by the Office of the Secretary, LR 38:351 (February 2012), amended by the Office of Business Development, LR 40:50 (January 2014), LR 40:1526 (August 2014), LR 41:

§2905. Certification of Amount of Credit

A. Prior to claiming a research and development tax credit on any tax return or selling any research and development tax credit, a person must apply for and obtain a credit certification from LED.

B. The application for a credit certification shall be submitted on a form provided by the LED and shall include, but not be limited to the following information:

1. an application fee equal to 0.5% of the amount of the tax credits applied for, with a minimum of \$500 and a maximum of \$15,000, payable to Louisiana Department of Economic Development;

2. appropriate supporting documentation:

a. for taxpayers employing 50 or more residents, a federal income tax return and evidence of the amount of federal research credit for the same taxable year;

b. for taxpayers employing up to 50 residents:

i. either:

(a). a federal income tax return and evidence of the amount of federal research credit for the same taxable year; or

(b). a request that LED enter into an attest engagement with a certified public accountant ("CPA") authorized to practice in Louisiana or a tax attorney who is selected by LED for a report which focuses on verification of the applicant's expenditures and claimed qualified research activities as well as pay the deposit for such report in accordance with La R.S. 36:104.1 and 47:6015; and

ii. evidence of the amount of qualified research expenses for the same taxable year;

B.2.c. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6015.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Business Resources Division, LR 30:977 (May 2004), amended by the Office of Business Development, LR 36:1768 (August 2010),

LR 38:351 (February 2012), LR 40:51 (January 2014), LR 40:1526 (August 2014), LR 41:

§2915. Agreed Upon Accounting Procedures

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6015.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 40:52 (January 2014), amended LR 40:1527 (August 2014), LR 41:

Provider Impact Statement

The proposed rulemaking should have no provider impact as described in HCR 170 of 2014.

Family Impact Statement

The proposed Rule changes have no impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Public Comments

Interested persons may submit written comments to Danielle Clapinski, Louisiana Department of Economic Development, P.O. Box 94185, Baton Rouge, LA 70804-9185; or physically delivered to Capitol Annex Building, office of the secretary, Second Floor, 1051 North Third Street, Baton Rouge, LA, 70802. Comments may also be sent by email to danielle.clapinski@la.gov. All comments must be received no later than 5 p.m., on October 26, 2015.

Public Hearing

A public hearing to receive comments on the Notice of Intent will be held on October 26, 2015 at 10 a.m. at the Department of Economic Development, 1051 North Third Street, Baton Rouge, LA 70802.

Anne G. Villa
Undersecretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Research and Development Tax Credit Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will be no incremental costs or savings to state or local governmental units due to the implementation of the proposed rule. The Department of Economic Development intends to administer the program with existing personnel.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Acts 133, 361 and 412 of the 2015 legislative session amended the Research and Development Tax Credit Program. Act 133 changes the nature of the research and development credits from a refundable credit to a non-refundable credit with a 5 year carryforward period. This legislative change will result in a net revenue increase to the state general fund of \$21 million in FY 2016 – FY 2018. However, that amount could be reduced by potential restructuring by corporations in order to produce liabilities that will generate credits. Act 361 provided for a new fee schedule for LED. Under the new fee schedule, the Research and Development Tax Credit Program will receive increased application fees equaling \$245,000 in agency self-generated revenues for FY 2016 – FY 2018, if historical participation is constant. Lastly, Act 412 directs LED to

directly engage with CPAs or tax attorneys for the performance of expense verification reports on certain participants of the research and development tax credit program. Program applicants will reimburse LED its direct cost for these engagements resulting in agency self-generated revenues of \$375,000 for FY 2016 – FY 2018. The addition of all three of these revenue increases results in a potential net revenue increase to the state of \$21.62 million annually for FY 2016 – FY 2018.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Applicants' income will decrease by the reduction in credits received if liabilities are smaller than credits and the higher application fee they will now owe at the time of application for credits.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies receiving benefits under this program will gain competitively over companies that do not receive the program's benefits. While employment may increase in participating businesses, employment may be lessened in other competing businesses that do not participate in the program.

Anne G. Villa
Undersecretary
1509#049

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 111—The Louisiana School,
District, and State Accountability System
(LAC 28:LXXXIII.301, 405, 409, and 1101)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 111—The Louisiana School, District, and State Accountability System*: §301, School Performance Score Goal; §405, Calculating a K-8 Assessment Index; §409, Calculating a 9-12 Assessment Index; and §1101, Letter Grade. The revisions eliminate the requirement that middle school students taking high school courses must take the 8th grade Louisiana Educational Assessment Program (LEAP) exams as well as the end-of-course (EOC) exams for any high school course they may be taking. Federal regulations requiring that students take both exams have changed, thus reducing the number of mandatory tests.

Title 28

EDUCATION

Part LXXXIII. Bulletin 111—The Louisiana School, District, and State Accountability System Chapter 3. School Performance Score Component §301. School Performance Score Goal

A. A school performance score (SPS) shall be calculated for each school. This score shall range from 0.0 to 150.0.

B. Each school shall receive its school performance scores under one site code regardless of its grade structure.

C. Final accountability results shall be issued by the fall semester of each year and all accountability reports will reflect the configuration of the school as it existed the prior spring semester.

1. For K-7 schools, the school performance score will consist entirely of one index based on assessments and progress points listed in the table below.

2. For K-8 schools, the school performance score will consist of an assessment index, dropout/credit accumulation index, and progress points.

K-8 School Performance Score Indices and Weights		
LEAP, iLEAP, EOC, and LAA 1	Grades K-7	100 percent
	Grades K-8	95 percent
Dropout/Credit Accumulation Index	Grade 8	5 percent
Progress Points	Grades 3-8	Up to 10 points

3. For schools with a grade 12, the school performance scores will include four indicators weighted equally and progress points as outlined in the table below.

High School Performance Score Indices and Weights		
End of Course Tests, LAA 1	Grades 9-12	25 percent
ACT* (Beginning in 2015-16, the ACT index shall also recognize WorkKeys. A concordance table comparing ACT to WorkKeys will be produced after the Spring 2015 administration.)	Grade 12	25 percent
Graduation Index	Grade 12	25 percent
Graduation Rate	Grade 12	25 percent
Progress points	Grades 10 and 12	Up to 10 points

*When calculating a school's ACT index score, students participating in the LAA 1 assessment shall not be included in the denominator of such calculation.

C.4. - D.3.c.i. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2737 (December 2003), amended LR 31:1512 (July 2005), LR 32:1017 (June 2006), LR 32:2034, 2035 (November 2006), LR 33:424 (March 2007), LR 33:2349 (November 2007), LR 33:2593 (December 2007), LR 34:430 (March 2008), LR 35:639 (April 2009), LR 36:1987 (September 2010), LR 38:3105 (December 2012), LR 39:305 (February 2013), LR 39:1421 (June 2013), LR 39:2441 (September 2013), LR 40:1313 (July 2014), LR 40:2507 (December 2014), LR 41:1481 (August 2015), LR 41:

Chapter 4. Assessment and Dropout/Credit Accumulation Index Calculations

§405. Calculating a K-8 Assessment Index

A. - E. ...

F. When middle schools students participate only in an EOC assessment and not the grade-level assessment in a given subject, EOC test results shall be used in the middle school's assessment index (100 for "good" and 150 for "excellent") and will be weighted by content as noted in the table above. Middle schools will also earn incentive points for all EOC scores of "good" or "excellent" earned during the same year in which the assessment was administered.

1. Incentive points will be awarded as follows:

- a. excellent = 50;
- b. good = 25.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:1021 (June 2006), amended LR 36:1989 (September 2010), LR 38:3106 (December 2012), LR 41:

§409. Calculating a 9-12 Assessment Index

A. All operational end-of-course (EOC) tests will be used in the calculation of the EOC assessment index.

1. All subjects will be weighted equally.

2. The EOC performance level will be used in the calculation of the EOC assessment index as described in the chart below.

EOC Performance Level	Index Point
Excellent	150
Good	100
Fair	0
Needs Improvement	0

3. Proficient test scores of "good" or "excellent" earned by students at a middle school will be included in the SPS calculations of the high school to which the student transfers as well. The scores for the high school will be included in the accountability cycle that corresponds with the students' first year of high school. EOC test scores considered "not proficient" ("needs improvement", "fair") will not be transferred, or banked, to the high school. Students will retake the test at the high school, and the first administration of the test at the high school will be used in the calculation of the assessment index the same year in which it was earned.

4. Beginning with the 2012-13 school year, students who are completing their third year in high school must have taken the algebra I and English II tests, or LAA 1. If they do not, the students will be assigned a score of zero and be counted as non-participants in high school testing. All students must be included in the assessment cohort regardless of course enrollment, grade assignment or program assignment.

B.1. - B.2.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:1021 (June 2006), amended LR 33:252 (February 2007), LR 36:1989 (September 2010), LR 37:2118 (July 2011), repromulgated LR 37:2382 (August 2011), amended LR 37:3200 (November 2011), LR 38:1212 (May 2012), LR 38:2357 (September 2012), LR 38:3106 (December 2012), LR 39:305 (February 2013), LR 39:1421 (June 2013), LR 40:1314 (July 2014), LR 41:

Chapter 11. School Performance Categories

§1101. Letter Grades

A. For the 2013-2014, 2014-2015 and 2015-2016 school years, letter grades shall be assigned pursuant to §303 of this bulletin. Thereafter schools will receive letter grades based on the school performance score (SPS).

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:2120 (July 2011), amended LR 38:3110 (December 2012), LR 40:760 (April 2014), LR 41:

Family Impact Statement

In accordance with section 953 and 974 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted,

amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.

2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.

3. Will the proposed Rule affect the functioning of the family? No.

4. Will the proposed Rule affect family earnings and family budget? No.

5. Will the proposed Rule affect the behavior and personal responsibility of children? No.

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2015, to Shan N.

Davis, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 111—The Louisiana School, District, and State Accountability System

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed policy revision will result in a small indeterminable savings for the state as a small number of middle school students will not be required to take two assessments thus reducing the number of exams administered and scored.

The revisions eliminate the requirement that middle school students taking high school courses must take the 8th grade Louisiana Educational Assessment Program (LEAP) exams as well as the End of Course (EOC) exams for any high school course they may be taking. Federal regulations requiring that students take both exams have changed, thus reducing the number of mandatory tests.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

This policy will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1509#040

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 140—Louisiana Early Childhood Care and
Education Network (LAC 28:CLXVII.Chapters 1-7)

The Board of Elementary and Secondary Education (BESE) has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedure Act, and R.S. 17.6 to adopt LAC 28:CLXVII, *Bulletin 140—Louisiana Early Childhood Care and Education Network*. Act 3 (Early Childhood Education Act) of the 2012 Regular Legislative Session required the creation of an early childhood care and education network; established the purposes of such network and the related duties and responsibilities of certain state agencies; provided for the development of early childhood education programs and standards; and provided for an accountability system for early childhood education programs. The purpose of Bulletin 140 is to establish the duties and responsibilities of the early childhood care and education network, local community networks and community network lead agencies, define

kindergarten readiness, and create a uniform assessment and accountability system for publicly-funded early childhood care and education sites and community networks that includes a performance profile indicative of performance.

The unified quality and improvement system will launch with a learning year in 2015-2016 whereby every early childhood site and community network will receive a practice performance profile. All publicly-funded early childhood programs will be required to participate, but there will be no funding or licensing consequences attached to the practice performance rating.

Title 28 EDUCATION

Part CLXVII. Bulletin 140—Louisiana Early Childhood Care and Education Network

Chapter 1. General Provisions

§101. Purpose

A. The purpose of this bulletin is to establish the duties and responsibilities of the early childhood care and education network, local community networks and community network lead agencies, define kindergarten readiness, and create a uniform assessment and accountability system for publicly-funded early childhood care and education sites and community networks that includes a performance profile indicative of performance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§103. Definitions

8(g) Program—the Student Enhancement Block Grant Program administered by the Board of Elementary and Secondary Education that provides funding through the Louisiana education quality start fund that may be used to serve at-risk PreK children.

Assessment—see *early childhood care and education assessment*.

At-Risk—children are considered at-risk if their family income is at or below 185 percent of the federal poverty level according to the United States Department of Agriculture, or if they are in foster care, or they are English language learners, or they are experiencing homelessness, or they meet the definition of an “infant or toddler with a disability” found in 34 CFR §303.21 for children ages birth to three years or a “child with a disability” found in 34 CFR §300.8 for children ages 3 and older.

BESE—Board of Elementary and Secondary Education.

Caregiver—any person legally obligated to provide or secure care for a child, including a parent, legal custodian, foster home parent, or other person providing a residence for the child.

CCAP—Child Care Assistance Program.

Child Care Assistance Program (CCAP)—federal program administered by the Louisiana Department of Education that makes payments to child care providers for child care services provided to eligible families.

CLASS[®]—Classroom Assessment Scoring System.

Classroom—see *early childhood care and education classroom*.

Classroom Assessment Scoring System (CLASS)[®]—a classroom observation-based system used to assess and rate classroom quality across multiple areas using a scale of one to seven.

Community Network Coverage Area—the geographic area of a community network, which typically is the same geographical area as the local school district or school districts, but may be other coverage areas, as determined by the community network and approved by the department.

Coverage Area—see *community network coverage area*.

Department—Louisiana Department of Education.

Early Childhood Care and Education Assessment (Assessment)—observation-based process used to determine whether children ages birth to five years are growing and developing across all the areas of development and learning provided in *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*.

Early Childhood Care and Education Classroom (Classroom)—an infant, toddler or PreK classroom.

Early Childhood Care and Education Performance Profile (Performance Profile)—information regarding performance in preparing children for kindergarten that is reported each school year for each publicly-funded site and community network composed of the site or community network’s performance rating and informational metrics.

Early Childhood Care and Education Performance Rating (Performance Rating)—measure of performance in preparing children for kindergarten that is reported each school year for each publicly-funded site and community network.

Early Childhood Care and Education Program (Program)—an early learning center-based or school-based organization that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten.

Early Childhood Care and Education Site (Site)—a distinct early learning center-based or school-based location that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten.

Early Learning Center—any child day care center, early Head Start, Head Start, or stand-alone prekindergarten program that is not attached to a school.

EarlySteps Program—program administered by the Louisiana Department of Health and Hospitals that provides early intervention services for infants and toddlers with disabilities ages birth to three years and their families according to the requirements of the Individuals with Disabilities Education Act (IDEA), part C.

Equitable Access—the point at which every family who wishes to enroll their at-risk child in a publicly-funded program is able to do so.

Fall Observation Period—observation period between August 1 and December 15 of each year.

Fiscal Year—July 1-June 30.

Full Day—at least 6 continuous hours per day or more than 20 hours per week of care and instruction aligned with a typical school day.

Head Start and Early Head Start Programs—federally-funded early childhood care and education programs that promote and teach school readiness to children ages birth to five from low-income families and provide services in the areas of education, social services for families, nutrition, family engagement, health and mental health, as well as

providing the physical plant and instructional staff members for such purposes (42 USC 9801 et seq., 45 CFR part 1300).

Individuals with Disabilities Education Act (IDEA), Part B—federal program administered by the Louisiana Department of Education that provides education funding for children with disabilities, ages 3 through 21.

Individuals with Disabilities Education Act (IDEA), Part C—federal program administered by the Louisiana Department of Health and Hospitals that provides early intervention services for infants and toddlers with disabilities ages birth to three years and their families to meet the developmental needs as identified by the individualized family services plan. See *EarlySteps Program*.

Infant—a child who has not yet reached 15 months of age.

Infant Classroom—a classroom in which the majority of children are infants.

Informational Metric—measure of early childhood care and education best practices at the site or community network level.

LA 4 Program—the Cecil J. Picard LA 4 Early Childhood Program that provides funding for PreK classrooms for four-year-old children who are eligible to enter kindergarten the following school year.

Lead Teacher—the early childhood care and education classroom teacher that is primarily responsible for the classroom and is required to meet the certification requirements in *Bulletin 746—Louisiana Standards for State Certification of School Personnel*.

Learning Year—the 2015-2016 school year shall be a learning year for the early childhood care and education network.

Nonpublic School Early Childhood Development Program (NSECD)—Louisiana program administered by the Department of Education that provides funding for four-year-old preschool in BESE-approved nonpublic schools and type III early learning centers.

Notice—written notice is considered given:

1. when it is sent by email or fax to the last email address or fax number furnished to the department;
2. when it is hand-delivered; or
3. on the fifth calendar day after it was mailed to the last mailing address furnished to the department.

NSECD—Nonpublic School Early Childhood Development program.

Performance Profile—see *early childhood care and education performance profile*.

Performance Rating—see *early childhood care and education performance rating*.

PreK—prekindergarten.

PreK Child—a child age 36 months to 5 years who has not yet entered kindergarten.

PreK Classroom—a classroom in which the majority of children are PreK children.

Program—see *Early Childhood Care and Education Program*.

Publicly-Funded Children—children ages birth to five years who have not yet entered kindergarten that are being served full day with funds from either CCAP, Early Head Start, Head Start, LA 4 Program, NSECD, 8(g) block grant, title 1 of ESEA, or IDEA part B in a full day setting.

Publicly-Funded Classroom—see *publicly-funded early childhood care and education classroom*.

Publicly-Funded Early Childhood Care and Education Classroom—any infant, toddler or PreK classroom that includes a publicly-funded child or children.

Publicly-Funded Early Childhood Care and Education Program—an early learning center-based or school-based organization that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten with funds from either CCAP, Early Head Start, Head Start, NSECD, LA 4 Program, 8(g) block grant, title 1 of ESEA or IDEA part B, or that is authorized to receive CCAP, or that participates in the quality start child care rating system.

Publicly-Funded Early Childhood Care and Education Site—a distinct early learning center-based or school-based location that is providing early childhood care and education to children ages birth to five years who have not yet entered kindergarten in a full-day setting with funds from either CCAP, Early Head Start, Head Start, NSECD, LA 4 Program, 8(g) block grant, title 1 of ESEA or IDEA part B, or that is authorized to receive CCAP, or that participates in the quality start child care rating system.

Publicly-Funded Program—see *publicly-funded early childhood care and education program*.

Publicly-Funded Site—see *publicly-funded early childhood care and education site*.

Site—see *early childhood care and education site*.

Spring Observation Period—observation period between January 1 and May 15 of each school year.

State Superintendent—state superintendent of education.

Title I—title I of the Elementary and Secondary Education Act (ESEA) that provides funding that may be used for preschool programs for disadvantaged children.

Third-Party Independent Contractor (Third-Party Contractor)—contractor that is separate from and independent of the lead agency and the community network with whom the department enters into a contract to perform CLASS[®] observations on behalf of the department.

Toddler—a child age 15 months to 36 months.

Toddler Classroom—a classroom in which the majority of children are toddlers.

Type III Early Learning Center—an early learning center that directly or indirectly receives state or federal funds from any source other than the federal food and nutrition programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.23 and R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 3. Early Childhood Care and Education Network

§301. Early Childhood Care and Education Network

A. The early childhood care and education network is established as the comprehensive and integrated network through which the Board of Elementary and Secondary Education (BESE) manages and oversees publicly-funded early childhood care and education programs in Louisiana to promote and improve kindergarten readiness.

B. The early childhood care and education network is comprised of the local community networks throughout the state.

C. The Department of Education (department), pursuant to authority delegated by BESE, manages and oversees the

administration of the early childhood care and education network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§303. BESE's Duties and Responsibilities

A. To facilitate the creation of the early childhood care and education network, BESE shall:

1. establish a definition of kindergarten readiness aligned with Louisiana content standards for elementary and secondary schools (see §305 of this Chapter);

2. establish performance targets for children under the age of three and academic standards for kindergarten readiness for three- and four-year old children to be used in publicly-funded early childhood education programs (see *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*);

3. create a uniform assessment and accountability system for publicly-funded early childhood care and education programs that includes an early childhood care and education performance rating (performance rating) indicative of performance (see Chapter 5 of this bulletin);

4. align the standards for the licensing of child care facilities, including the requirements for participation in the Louisiana quality start child care rating system, with the standards established for early childhood education programs (see *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Regulations* and *Bulletin 139—The Louisiana Child Care and Development Fund Programs*).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§305. Kindergarten Readiness Definition

A. Children who are ready for kindergarten are expected to demonstrate:

1. cognitive abilities, which include knowledge and skills in:

a. early literacy, such as phonological awareness, print concepts, alphabetic understanding, vocabulary, listening comprehension, and emergent writing;

b. basic numeracy concepts, such as rote counting and number awareness, sorting, classifying, comparing, patterning, and spatial relationships;

2. basic science concepts, such as making observations, exploring the world using their senses, and using appropriate scientific vocabulary related to topics;

3. basic social studies concepts, such as self-awareness and their relationship to family and community, and an awareness of money and time;

4. response to and participation in music, movement, visual and dramatic arts experiences and activities;

5. abilities, either assisted or unassisted, that show an awareness of health, hygiene, and environmental hazards, in addition to gross and fine motor skills;

6. social and emotional competencies, including self-regulation, self-identity, self-reliance, respect for others, and interpersonal skills; and

7. approaches to learning, such as reasoning and problem-solving, engagement, persistence, and eagerness to learn.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§307. Publicly-Funded Early Childhood Care and Education Programs and Community Networks

A. Publicly-Funded Early Childhood Care and Education Program (Publicly-Funded Program)

1. Each publicly-funded program shall participate in the:

a. membership in the community network for its coverage area;

b. early childhood care and education accountability system (accountability system), as provided in Chapter 5; and

c. coordinated enrollment process, as provided in Chapter 7.

2. Any publicly-funded program that does not comply with Paragraph A.2 of this Section may be subject to the loss of its public funding.

B. Community Network

1. Each community network shall:

a. participate in the early childhood care and education accountability system (accountability system);

b. develop and implement a coordinated observation plan for the community network;

c. develop and implement a coordinated enrollment process for the community network;

d. have a lead agency;

e. support the department in disseminating and collecting an annual survey from lead teachers and families of every publicly-funded child; and

f. address other needs as identified by the community network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§309. Community Network Lead Agency

A. A community network lead agency is either a state agency, a local public school system, a non-profit or for-profit corporation having an educational or social services mission, including but not limited to a nonprofit corporation of a philanthropic or policy nature, a Louisiana public postsecondary institution, or a nonprofit corporation established by the governing authority of a parish or municipality, that is approved by BESE and that:

1. serves as the fiscal agent of the community network;

2. coordinates the duties and responsibilities of the community network; and

3. acts as the liaison between the community network and the department.

B. Duties and Responsibilities

1. The lead agency shall be responsible for coordinating the duties and responsibilities of the community network pertaining to:

a. coordinated Classroom Assessment Scoring System (*CLASS*[®]) observations, as provided in §503, which includes but is not limited to:

i. submitting the community network's annual plan for coordinated *CLASS*[®] observations to the department;

ii. submitting all *CLASS*[®] observation results to the department; and

iii. sharing each publicly-funded program's *CLASS*[®] observation results with that publicly-funded program and sharing the aggregate *CLASS*[®] observation results for the community network with all publicly-funded programs in the community network, at least monthly;

b. coordinated enrollment, as provided in Chapter 7, which includes but is not limited to:

i. ensuring a coordinated enrollment process is operated by the community network each year as provided in §703;

ii. submitting to the department the community network's coordinated enrollment plan, which shall include signatures from each publicly-funded program in the community network indicating approval of the plan and shall describe how the community network will ensure coordinated enrollment for families within the community network who want to enroll their infant, toddler, or PreK children in a publicly-funded program in the community network;

iii. submitting counts to the department twice a year reflecting the total enrollment of at-risk children in all programs in the community network as of October 1 and as of February 1, according to the age cohorts provided in §701;

iv. submitting an annual request for funding to the department for publicly-funded programs in the community network that is based on the results of the coordinated enrollment process used in the community network and is subject to the requirements provided in §709; and

v. working with all publicly-funded programs in the community network to maximize all available resources to increase the quality of and access to the publicly-funded programs for at-risk children;

c. accountability system reporting, as provided in §515;

d. data verification, as provided in §517;

e. requesting waivers, as provided in §519;

f. submitting appeals, as provided in §521; and

g. demonstrating progress toward implementation of coordinated enrollment as provided in §707.

2. The lead agency shall not charge any publicly-funded program for any part of the coordinated observation process and shall not require publicly-funded programs to provide staff to conduct *CLASS*[®] observations.

C. Selection and Approval

1. Lead agencies shall be approved by BESE.

2. The department shall identify potential lead agencies through a competitive process and submit them to BESE for approval.

2. Applicants for lead agency shall demonstrate support from all publicly-funded programs within the community network by obtaining signatures from each and submitting them to the department in the competitive process.

3. By June 30 of each year, the department shall recommend the identified lead agencies to BESE for approval.

4. If BESE has not approved a lead agency for a community network by July 1, the department shall serve as lead agency for the community network.

5. Lead agencies approved by BESE shall serve for the fiscal year beginning July 1 and ending June 30.

D. Contracts

1. Lead agencies approved by BESE shall enter into a lead agency agreement with the department.

2. The lead agency may enter into a contract or agreement with an individual or entity for performance of specific tasks within the duties and responsibilities of the lead agency, but the lead agency remains responsible for satisfactory completion of the tasks.

E. Funding

1. Subject to available funding, lead agencies shall be funded based on the number of early childhood care and education classrooms (classrooms) in the network.

a. Lead agencies shall be notified of their total funding for the following fiscal year by June 30.

b. Lead agencies shall use funding solely to fulfill the duties and responsibilities of the community network as provided in this bulletin.

c. If the department is required to serve as a lead agency, the department shall be funded in the same manner as any other lead agency.

F. Audit

1. BESE may request a financial audit of the lead agency's use of funds allocated to it.

2. Audits shall be at the department's expense.

3. If a lead agency improperly uses its allocated funds, the lead agency may be required to repay the improperly used amount.

G. Termination of Lead Agency Approval

1. If a lead agency fails to satisfactorily and timely comply with the duties and responsibilities contained in this Bulletin or with any additional duties and responsibilities established in writing during the competitive process, the department shall notify the lead agency, and all publicly-funded programs within the community network in writing and specify any corrective actions that may be required.

2. Within 30 calendar days of receiving such notice, the lead agency shall submit in writing to the department certification that the corrective actions have been taken or are in the process of being taken and submit a timely implementation schedule for department approval.

3. If the lead agency does not respond in writing in a timely or satisfactory manner or adhere to the implementation schedule approved by the department, either or both of the following actions may occur.

a. The department may withhold funds from the lead agency for any work not yet performed.

b. The department may make a recommendation to BESE that approval of the lead agency be terminated.

4. If BESE terminates a lead agency's approval and does not approve a new lead agency, the department shall serve as lead agency for a community network.

5. The department shall notify all publicly-funded programs in a community network of any change in that community network's lead agency.

6. If a lead agency's approval is terminated:

a. The entity shall be ineligible to serve as lead agency in the community network from which its approval was terminated for a minimum period of 24 months.

b. If the entity serves as lead agency for more than one community network, the entity may continue to serve as lead agency for any community network for which its approval has not been terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§311. Complaints

A. Any program or individual may submit a written complaint to the department regarding the action or inaction of the lead agency in its community network.

B. A complaint shall be submitted in writing within 30 calendar days of the action or inaction of the lead agency upon which the complaint is based.

C. All complaints shall clearly state the action or inaction upon which the complaint is based and provide specific facts and documentation supporting the complaint.

D. The department shall act upon and respond in writing to all signed complainants within 30 calendar days of receiving the complaint.

E. Anonymous complaints may be acted upon at the discretion of the department.

F. Lead agencies shall not retaliate in any manner against a program or individual that submits a complaint to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§313. Academic Approval for Type III Early Learning Centers

A. All type III early learning centers shall meet the performance and academic standards of the early childhood care and education network regarding kindergarten readiness as provided in R.S. 17:407.36(C).

B. Type III early learning centers meeting the performance and academic standards shall receive academic approval from the department. Academic approval is verification by the department that the center is meeting the required performance and academic standards.

C. Initial Academic Approval for 2015-2016 Fiscal Year

1. Existing Type III Early Learning Centers

a. Academic approval shall be granted for the 2015-2016 fiscal year to any existing type III early learning center that has submitted a signed copy of program partner profile and assurances (assurances) to the lead agency of the community network in its area, and is thereby agreeing to:

i. membership in the community network;

ii. participation in the early childhood care and education accountability system, as provided in Chapter 5; and

iii. participation in the coordinated enrollment process, as provided in Chapter 7.

b. The community network shall submit copies of Assurances signed by type III early learning centers to the department within seven calendar days of receiving them or prior to July 1, 2015, whichever is earlier.

c. The department shall send written notice of academic approval to each type III early learning center that has submitted signed assurances to its community network in compliance with Subparagraph C.1.a of this Subsection by July 1, 2015.

2. Applicants for New Type III Early Learning Center Licenses

a. In order to obtain the initial academic approval required to be licensed as a type III early learning center, an applicant for a type III early learning center license must become a member of the community network in its coverage area and submit a signed copy of the program partner profile and assurances (assurances) to the lead agency of the community network thereby agreeing to:

i. membership in the community network;

ii. participation in the early childhood care and education accountability system, as provided in Chapter 5; and

iii. participation in the coordinated enrollment process, as provided in Chapter 7.

b. The department shall send written notice of academic approval to each type III early learning center that has submitted signed assurances to its community network in compliance with Subparagraph C.2.a of this Section within 30 days of receipt of the signed assurances.

D. Academic approval shall be valid for the fiscal year, July 1-June 30, for which it is granted.

E. Academic approval is granted to a specific owner and a specific location and is not transferable. If a type III early learning center changes owners or location, it is considered a new operation, and academic approval for the new owner or location must be obtained prior to beginning operations under new ownership or at the new location.

F. Upon a change of ownership or change of location, the academic approval granted to the original owner or at the original location becomes null and void.

G. Renewal

1. Prior to July 1 of each year, the department shall send notice to each type III early learning center that has academic approval providing one of the following:

a. renewal of academic approval for the center;

b. notice of the center's failure to comply with specific requirements in Subsection A and specific corrective actions that must be taken by a specified date in order for academic approval to be renewed; or

c. if an early learning center has received the notice outlined in Subparagraph H.2.a of this Section within the academic year and the center has not provided the required certifications and completed the stated corrective actions, the department may terminate the center's academic approval as provided in Subparagraph H.2.c of this Section and send notice of termination of the center's academic approval.

H. Termination of Academic Approval

1. The department may terminate academic approval for:

a. violations of any provisions of this bulletin related to the performance and academic standards of the early childhood care and education network;

b. failure to timely comply with a corrective action plan provided by the department; or

c. any act of fraud, such as the submission of false or altered documents or information.

2. Notice

a. If a type III early learning center is in violation of any provision in Subsection A of this Section, the department shall notify the center in writing and may specify any corrective actions that shall be required to retain academic approval.

b. Within 30 calendar days of receiving such notice, the center shall submit certification in writing to the department that the corrective actions have been taken or are in the process of being taken in compliance with the schedule provided and certification that the center will remain in compliance with all applicable regulations.

c. If the type III early learning center does not respond in a timely or satisfactory manner or adhere to the implementation schedule for required corrective actions, the department may terminate the center's academic approval by sending written notice of termination to the center.

d. Termination of the center's academic approval shall be effective when notice of termination is given.

I. Appeal Procedure

1. BESE shall have the authority to grant an appeal of the termination of a type III early learning center's academic approval.

2. The appeal procedure shall be used when needed to address unforeseen and aberrant factors impacting type III early learning centers or when needed to address issues that arise when the literal application of the academic approval regulations does not consider certain unforeseen and unusual circumstances.

3. A type III early learning center may request an appeal of the termination of its academic approval by submitting a written request for an appeal to the department within 15 calendar days of being given notice of termination of its academic approval.

4. All appeal requests shall clearly state the specific reasons for requesting the appeal and the reasons why the appeal should be granted and shall include any necessary supporting documentation.

5. The department shall review all timely submitted appeal requests and make recommendations to BESE during the first regularly scheduled BESE meeting following receipt of the appeal requests, or during the second regularly scheduled BESE meeting if an appeal request is received within 10 working days of the next regularly scheduled BESE meeting. Within this interval, the department shall notify the center of its recommendation and allow the center to respond in writing. The department's recommendation and the center's response shall be submitted to BESE for final disposition.

6. An early learning center that appeals the termination of its academic approval shall retain its academic approval during the appeal process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.36(C) and R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

**Chapter 5. Early Childhood Care and Education
Accountability System**

**§501. Early Childhood Care and Education
Accountability System (Accountability System)**

A. The early childhood care and education accountability system (accountability system) is the uniform accountability system created pursuant to R.S. 17:407.23(B)(3) and used to

evaluate the performance of publicly-funded early childhood care and education sites and community networks in preparing children for kindergarten and to assign a performance profile to each site and community network.

B. Participants

1. Publicly-Funded Early Childhood Care and Education Sites (Publicly-Funded Sites)

a. All publicly-funded sites with at least one classroom on October 1 shall participate and shall be included in the accountability system.

b. All publicly-funded sites with at least one classroom on October 1 and one classroom on February 1 shall participate and shall receive a performance profile for the school year.

c. All classrooms in existence on either October 1 or February 1 in a publicly-funded site shall be included in the accountability system for that school year.

d. Publicly-funded sites that open after October 1 of a school year shall not participate in the accountability system, as provided in this Chapter, until the start of the following school year.

2. Community Networks

a. All community networks shall participate and shall be included in the accountability system and shall receive a performance profile for the school year.

b. If any publicly-funded site discontinues participation in a community network after October 1 by changing funding source, license type, or closing, its performance shall remain part of the community network performance profile for the school year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§503. Coordinated Observation Plan and Observation Requirements

A. Coordinated observation is the local process by which each community network ensures that every classroom in a publicly-funded site in the community network receives two CLASS® observations each school year.

B. CLASS® Observation Requirements

1. A CLASS® observation is an observation of a classroom using the appropriate toddler or PreK CLASS® using all domains, typically occurring during the morning, in which a reliable observer conducts four 20-minute cycles of observation and note-taking followed by at least 10 minutes of scoring after each observation cycle.

2. Domains and Dimensions

a. CLASS® observations for toddler classrooms shall include both toddler CLASS® domains, which are emotional and behavioral support and engaged support for learning, and all dimensions contained within.

b. CLASS® observations for PreK classrooms shall include all three PreK CLASS® domains, which are emotional support, classroom organization, and instructional support, and all dimensions contained within.

3. Required Observations

a. All toddler and PreK classrooms in a publicly-funded site shall receive two CLASS® observations during the school year conducted by the community network.

b. One observation shall occur during the fall observation period, if the classroom is in existence on October 1, and the other shall occur during the spring

observation period, if the classroom is in existence on February 1.

c. *CLASS*[®] observations conducted by third-party contractors hired by the department shall not count towards this requirement.

4. Use of Toddler or PreK *CLASS*[®]. Classrooms shall be observed with the same *CLASS*[®] throughout the school year based on the composition of the classroom when the observation plan required in §503.C is submitted according to the following:

a. a classroom that only has infant children or a classroom that has a mix of infant and toddler children in which a majority are infant children shall not be observed;

b. a classroom that has all toddler children or a classroom that has a mix of infant and toddler children in which the majority are toddler children shall be observed with the toddler *CLASS*[®];

c. a classroom that has all PreK children or a classroom that has a mix of toddler and PreK children in which the majority are PreK children shall be observed with the PreK *CLASS*[®].

C. Coordinated Observation Plan

1. Each community network shall submit for department approval no later than September 30 a written annual plan for coordinated observation using *CLASS*[®] that at a minimum includes:

a. the number of *CLASS*[®] observers who will conduct observations;

b. the total number and the location of toddler and PreK classrooms that must be observed;

c. an observation schedule that includes two observations for each toddler and PreK classroom identified in Subparagraph B.3.b of this Section, with one observation scheduled during the fall observation period and one during the spring observation period; and

d. a plan to ensure reliable data that includes the following requirements:

i. all observers are reliable, which is defined as all observers having a certification achieved by completing and passing all trainings and assessments required by Teachstone to conduct a *CLASS*[®] observation with validity and fidelity;

ii. all observers maintain inter-rater reliability and fidelity. Inter-rater reliability occurs when two or more observers produce consistent observation results for the same classroom at the same time;

iii. the community network conducts inter-rater reliability observation checks for 10 percent of all classrooms observed; and

iv. no observer shall conduct an observation in which the observer is an immediate family member, as defined in R.S. 42:1101, of a teacher in the classroom being observed or an immediate family member of an individual who supervises or provides training or technical assistance to a teacher in the classroom being observed or has a direct financial interest in the site where the classroom is being observed.

D. Waiver

1. The state superintendent of education shall have the authority to grant waivers to lead agencies for specific requirements of the coordinated observation plan or observation requirements included in this Chapter, with the exception of Clause C.1.d.iv of this Section.

2. Lead agencies seeking a waiver shall submit a written request the department prior to or at the time of the submission of the coordinated enrollment plan. The request shall cite the specific requirement for which a waiver is being requested and shall clearly state the reasons why the waiver is being requested and why it should be granted. Waiver requests shall include any supporting documentation that substantiates the need for the waiver.

3. The department shall respond in writing to waiver requests within 30 calendar days after receiving the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§505. Performance Profiles

A. The performance profiles for publicly-funded sites and for community networks shall include:

1. a performance rating as provided in §509 for publicly-funded sites and as provided in §511 community networks; and

2. informational metrics as provided in §513.

B. Each publicly-funded site and each community network shall receive a performance profile based on performance each school year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§507. Performance Profile Implementation Timeline

A. The 2015-2016 school year shall be an learning year for publicly-funded sites and community networks.

1. A learning year is a year in which there are no consequences on publicly-funded sites or community networks as a result of their performance profile.

2. Performance profiles for the 2015-2016 learning year shall clearly indicate that the performance profile is practice and is from a learning year.

B. Every publicly-funded site, except those that begin operating after October 1, and every community network shall participate in the accountability system for the 2015-2016 learning year and shall receive a practice performance profile as provided in §501.

1. Type III early learning centers that do not participate in the accountability system may have their academic approval terminated.

2. All other publicly-funded sites that do not participate in the accountability system may be subject to the loss of public funding.

C. The 2016-2017 school year shall be the first school year in which publicly-funded sites and community networks are accountable for the performance rating earned.

D. Prior to the start of the 2016-2017 school year, BESE shall review this Chapter and revise as necessary based on learnings from the 2015-2016 learning year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§509. Performance Rating Calculations for Publicly-Funded Sites

A. The performance rating for each publicly-funded site shall be based on the average of the domain-level toddler

and PreK observation results from the fall and spring observation periods for all toddler and PreK classrooms within the site.

1. BESE may include a weight for improvement beginning with the 2016-2017 school year.

B. Any classroom in a publicly-funded site that does not have the observations required in §503 or does not have all results reported, shall have a score of one assigned to each missing *CLASS*[®] domain score. The score of one for missing or not-reported observation results shall be included in the performance rating calculation for that site and the number of missing or not-reported observation results shall be reported on the performance profile.

1. Lead agencies may have their approval terminated as provided in §309.G for incomplete observations or observation results not reported.

2. Any site or program that has diligently sought observations from the lead agency, including written evidence of such efforts, and that has not been provided such observations, may request of BESE an appeal of its performance rating as described in §521. BESE shall consider diligent efforts and evidence thereof in determining the appeal.

3. Prior to the issuance of the publicly-funded site or community network profiles, the department shall provide to the Advisory Council on Early Childhood Care and Education committee members and to BESE members a list of all publicly funded sites receiving a score of one due to a missing or not-reported *CLASS*[®] domain score and the number of such ones received by each site.

C. The department shall compare the domain-level results from observations of classrooms conducted by the department's third-party contractors to the domain-level results from observations conducted by the community network for each publicly-funded site.

1. In calculating the performance rating, the department shall replace domain-level results from classroom observations conducted by community networks with the domain-level results from observations conducted by the department's third-party contractors for any single domain in which the results differ by more than one point and shall calculate the performance rating using the replaced results.

2. The department shall monitor the domain-level observation results of classroom observations conducted by community networks for each publicly-funded site, including by observer, and domain-level observation results conducted by the department's third-party contractor for each publicly-funded site.

a. For the 2015-2016 learning year, if the observation results conducted by community networks are consistently different by more than one point from observation results conducted by the department's third-party contractors, the department may replace all of the community network's observation results for a publicly-funded site with the results from the department's third-party contractors, including those results that do not differ by at least one point.

b. The department shall review results from the 2015-2016 learning year and recommend policy to BESE for 2016-2017 and beyond.

D. The performance rating for each site shall be based on the following numerical scale:

1. 6.0-7.0—excellent;
2. 3.0-5.99—proficient;
3. 1.0-2.99—needs improvement.

E. The numerical scale and performance rating shall be used for each *CLASS*[®] domain and for the overall performance rating.

F. BESE may transition to a five-level rating scale beginning with the 2017-2018 school year.

G. BESE shall review the overall rating calculation, including but not limited to data collected on the informational metrics of best practices, prior to the 2016-2017 school year and determine whether additional factors should be added to the rating calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§511. Performance Rating Calculations for Community Networks

A. The performance rating for a community network shall be calculated as follows.

1. *CLASS*[®] observation results shall be 50 percent of a community network performance rating.

2. An equitable access score for four-year-olds shall be 50 percent of the community network performance rating.

3. BESE may include a weight for improvement on equitable access beginning with the 2016-2017 school year.

B. The *CLASS*[®] observation results shall be determined by averaging the results of all fall and spring domain-level toddler and PreK observation results for all toddler and PreK classrooms within the community network.

1. Any classroom in a site that does not have the observations required in §503, or has not had all observation results reported, shall have a score of one assigned to each missing *CLASS*[®] domain. The score of one for missing observation or not-reported results shall be included in the performance rating calculation for the community network and the number of missing or not-reported observation results shall be reported on the community network's performance profile.

a. Lead agencies may be subject to termination as provided in §309.G for incomplete observations or observation results not reported.

2. The department shall compare the domain-level results from observations of classrooms conducted by the department's third-party contractors to the domain-level results from observations conducted by community network for each publicly-funded site.

a. In calculating the performance rating, the department shall replace domain-level results from classroom observations conducted by community network with the domain-level results from observations conducted by the department's third-party contractor for any single domain in which the results differ by more than one point and shall calculate the performance rating using the replaced results.

b. The department shall monitor domain-level observation results of classroom observations conducted by community network for each publicly-funded site, including

by observer, and domain-level observation results conducted by the department's third-party contractors for each publicly-funded site.

i. For the 2015-2016 learning year, if the observation results conducted by a community network are consistently different by more than one point from observation results conducted by the department's third-party contractor, the department may replace all of the community network's observation results for a publicly-funded site with the results from the department's third-party contractor for that site, including those results that do not differ by at least one point.

ii. The department shall review results from the 2015-2016 school learning year and recommend policy to BESE for 2016-2017 and beyond.

C. The equitable access score shall be determined by calculating the access achieved by the community network for all at-risk four-year-old children in the community network coverage area. Points are earned on a seven-point scale according to:

Percentage of At-Risk Four-Year-Olds Served	Points
95-100 percent	7
90-94.9 percent	6
85-89.9 percent	5
80-84.9 percent	4
75-79.9 percent	3
70-74.9 percent	2
0-69.9 percent	1

D. The performance rating for each community network shall be based on the following numerical scale:

1. 6.0-7.0—excellent;
2. 3.0-5.99—proficient;
3. 1.0-2.99—needs improvement.

E. The numerical scale and performance rating shall be used for reporting each CLASS® domain and the overall performance rating.

F. BESE may transition to a five-level rating scale beginning with the 2017-2018 academic year.

G. BESE shall review the overall rating calculation, including but not limited to data collected on the informational metrics of best practices, prior to the 2016-2017 school year and determine whether additional factors should be added to the rating calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§513. Informational Metrics of Best Practices

A. Informational metrics are measures of a publicly-funded site and a community network's use of the following early childhood care and education best practices.

1. Child Assessment that Informs Instruction

a. Ready to Assess. Publicly-funded sites ensure all lead teachers have certification of reliability as provided by the assessment creator for each school year.

b. Ongoing Assessment. Publicly-funded sites ensure all publicly-funded children receive completed assessments in October, February, and May. Publicly-funded sites shall obtain approval from the department prior to using child assessment tools different from the assessment tool provided by the department.

c. Assessing Accurately. Publicly-funded sites ensure there is an assessment portfolio for every publicly-funded child that provides evidence of the assessment rating for that school year.

2. Investment in Quality Measures

a. Teacher/Child Ratios. Publicly-funded sites maintain teacher/child ratios based on the age of children that are at or better than the minimum standards required in BESE *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Regulations*.

i. To achieve gold level ratios, publicly-funded sites use the following teacher/child ratios and group sizes.

Age	Teacher/Child Ratio	Maximum Group Size
Birth to 1 year	1:4	8
1 year to 2 years	1:4	8
2 years to 3 years	1:6	12
3 years to 4 years	1:8	16
4 years to 5 years	1:10	20

ii. To achieve silver level ratios, publicly-funded sites use the following teacher/child ratios and group sizes.

Age	Teacher/Child Ratio	Maximum Group Size
Birth to 1 year	1:4	8
1 year to 2 years	1:6	12
2 years to 3 years	1:8	16
3 years to 4 years	1:10	20
4 years to 5 years	1:12	24

iii. To achieve bronze level ratios, publicly-funded sites use the minimum ratio standards required in BESE *Bulletin 137—The Louisiana Licensing Early Learning Center Licensing Regulations*.

a. Teacher Preparation. Publicly-funded sites ensure lead teachers meet or exceed credential requirements for publicly-funded classrooms provided in BESE *Bulletin 746—Louisiana Standards for State Certification of School Personnel*.

b. Standards-Based Curriculum. Publicly-funded sites use a curriculum that is aligned to BESE *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*.

3. Family Engagement and Supports

a. Publicly-funded sites and community networks engage families and ensure families are satisfied with their children's care and education experience, as measured through a family survey that will be produced and managed by the department.

4. Community Network Supports (Reported at the Community Network Level Only)

a. Community networks ensure teachers have access to supports to address their professional development needs and aid them in supporting children's learning and development.

b. Community networks and publicly-funded sites ensure children are prepared for kindergarten.

B. The performance profile shall report the publicly-funded site and community network's use of the best practices identified in Subsection A of this Section by reporting the following informational metrics:

1. child assessment that informs instruction:

- a. ready to assess—the percent of reliable lead teachers in each site and community network;
- b. ongoing assessment—the percent of publicly-funded children who receive at least three assessments per school year in each program and community network; and
- c. assessing accurately—the level to which assessment portfolios substantiate the assessment ratings for publicly-funded children in each site and community network;

2. investment in quality measures:

- a. teacher/child ratios—the level of ratios used: gold, silver, or bronze;
- b. prepared teachers—the percent of lead teachers holding varying levels of academic credentials and teacher certification for each site and community network; and
- c. standards-based curriculum—the extent to which the curriculum in use by a site is aligned to the early learning and development standards contained in BESE *Bulletin 136—The Louisiana Standards for Early Childhood Care and Education Programs Serving Children Birth-Five Years*;

3. family engagement and supports:

- a. for each site, the level of satisfaction community network families have reported with the site; and
- b. for each community network, the level of satisfaction community network families have reported with the coordinated enrollment process;

4. community network supports (reported at the community network level only):

- a. the level of satisfaction lead teachers have reported with the supports received from the community network; and
- b. the percent of publicly-funded four-year-old children that are kindergarten ready at the beginning and end of the school year based on results from the child assessment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§515. Reporting for the Accountability System

A. Lead agencies shall report to the department, in the manner specified by the department, the following:

- 1. classroom counts:
 - a. by October 31, the number of classrooms serving infant, toddler and PreK children in each publicly-funded site on October 1;
 - b. by February 28, the number of classrooms serving infant, toddler, and PreK children in each publicly-funded site on February 1; and
 - c. by February 28, the number of classrooms in the February 1 count that have been added or removed since the October 1 count;
- 2. child counts:
 - a. by October 31, the number of publicly-funded children in each publicly-funded site on October 1;
 - b. by February 28, the number of publicly-funded children in each publicly-funded site on February 1; and
 - c. by February 28, the number of publicly-funded children by site in the February 1 count that have been added or removed since the October 1 count;

3. CLASS® observation results:

a. within 10 business days after the observation, unless upon written request from the lead agency, the department grants a written extension of time for a specific observation based on the extenuating circumstances provided in the written request;

b. all fall observation period data by December 15; and

c. all spring observation period data by May 15;

4. child assessment results for publicly-funded infants, toddlers and PreK children by October 31, February 28, and May 31.

B. Publicly-funded sites shall report to the department by October 31, in the manner specified by the department, the following:

1. number of lead teachers with certification of reliability on the ongoing assessment used in the community network;

2. teacher/child ratios used in the site;

3. credential and certification status of each lead teacher; and

4. curriculum used in each classroom.

C. The department shall report to lead agencies on a monthly basis the number of CLASS® observations that have been submitted for publicly-funded programs in that community network.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§517. Data Verification

A. The department shall provide all non-survey data contributing to the performance profile for publicly-funded sites and community networks to each lead agency prior to publishing the performance rating.

B. The department shall provide lead agencies 30 calendar days for final review, correction, and verification of data for the performance profiles.

1. The lead agency shall create and implement a community network data certification procedure that requires review of all performance profile data for each site during the data certification period.

2. The department may request the certification procedure from each lead agency.

3. All data correction must take place during the 30 calendar day period.

4. Data corrections may be submitted for the following reasons:

a. CLASS® observations results have been reported incorrectly or

b. CLASS® observation results were not reported.

5. The department shall review all data corrections and grant approval of those corrections that are proven valid.

6. The department may request additional documentation to support the validity of the changes.

C. The department shall act upon and respond in writing within 30 calendar days of receiving a signed report from the general public regarding potential irregularities in data reporting.

D. Anonymous complaints may be acted upon at the discretion of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§519. Waivers of Accountability System Requirements

A. The state superintendent of education (state superintendent) shall have the authority to grant waivers to publicly-funded sites and community networks for specific requirements of the accountability system included in this Chapter.

1. Community Networks

a. Prior to October 1, any lead agency requesting a waiver on behalf of the community network from a requirement of the accountability system shall submit a request in writing to the department.

b. After October 1 and prior to the start of the data verification period established in §517, any lead agency with extenuating circumstances arising after October 1 may request a waiver by submitting a written request to the department that shall clearly state the extenuating circumstances on which the request is based.

2. Publicly-Funded Sites

a. Prior to October 1, any publicly-funded site requesting a waiver from a requirement of the accountability system shall submit a request in writing to the department and shall include a written statement of support for the waiver from the community network lead agency.

b. After October 1 and prior to the start of the data verification period established in §517, any publicly-funded site with extenuating circumstances arising after October 1 may request a waiver by submitting a written request to the department that shall clearly state the extenuating circumstances on which the request is based. The request shall include a written statement of support for the waiver from the community network lead agency.

B. All waiver requests shall cite the requirement(s) from which a waiver is being requested and shall clearly state the reasons why it being requested and why it should be granted. Waiver request shall include any supporting documentation that substantiates the need for the waiver.

C. The department shall respond in writing to waiver requests within 30 calendar days after receiving the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§521. Performance Profile Appeals Procedure

A. BESE shall have the authority to grant an appeal of a publicly-funded site or community network's performance profile.

B. The appeal procedure shall be used when needed to address unforeseen and aberrant factors impacting publicly-funded sites and community networks or when needed to address issues that arise when the literal application of the accountability system regulations does not consider certain unforeseen and unusual circumstances.

C. A publicly-funded site or community network may request an appeal of its performance profile by submitting a written request for an appeal to the department within 15 calendar days of the department's release of the publicly-funded site or community network's performance profile.

D. All appeal requests shall clearly state the specific reasons for requesting the appeal and the reasons why the appeal should be granted and shall include any necessary supporting documentation.

E. The lead agency shall submit a written request for appeal on behalf of a community network that wishes to appeal its performance profile.

F. The department shall review all timely submitted appeal requests and make a recommendation to BESE during the first regularly scheduled BESE meeting following receipt of the appeal request, or during the second regularly scheduled BESE meeting if the appeal request is received within ten working days of the first regularly scheduled BESE meeting. Within this interval, the department shall notify the publicly-funded site or community network of its recommendation and allow the site or community network to respond in writing. The department's recommendation and the site or community network's response shall be submitted to BESE for final disposition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§523. Disaster Consideration for Programs and Community Networks

A. A severe impact site meets either of the following conditions associated with disasters:

1. the site was closed, due to the disaster, for 18 or more consecutive school days during a given school year; or
2. the site gained or lost 25 percent or more of its population due to the disaster.

B. A severe impact community network is a community network that consists of 25 percent or more severe impact sites.

C. Severe impact sites and severe impact community networks qualify for a waiver for up to one school year from participation in the accountability system.

1. BESE shall not issue a performance profile for any severe impact site or severe impact community network for the school year in which the disaster occurred unless the site or community network requests that the performance profile be issued.

2. BESE shall not include severe impact site accountability system results in the performance profile for a community network that does not meet the severe impact criteria but has severe impact sites.

D. Community network lead agencies and sites may address situations not part of the severe impact disaster process through the waiver process for accountability system requirements set forth in §519.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 7. Coordinated Enrollment

§701. Age Cohorts

A. Children shall be placed in a single age cohort for counting purposes in a school year. Each child shall be placed in the appropriate age cohort at the beginning of the school year and shall remain in that age cohort for the entire school year.

B. A child's age cohort shall be determined by the child's age on September 30 of the school year.

C. Children shall be placed in age cohorts for a school year as follows:

1. four-year-olds are children who have reached or will reach their fourth birthday on or before September 30;
2. three-year-olds are children who have reached or will reach their third birthday on or before September 30;
3. two-year-olds are children who have reached or will reach their second birthday on or before September 30;
4. one-year-olds are children who have reached or will reach their first birthday on or before September 30; and
5. children ages birth to one year are children who have not reached and will not reach their first birthday by or before September 30.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§703. Coordinated Enrollment Process

A. Coordinated enrollment is the process developed and implemented by a community network to coordinate enrollment for infant, toddler, and PreK children in the community network whose families want to enroll them in a publicly-funded program in the community network.

B. The coordinated enrollment process consists of:

1. a coordinated information campaign through which the community network informs families about the availability of publicly-funded programs serving children ages birth to five years;
2. a coordinated eligibility determination through which the community network coordinates enrollment, eligibility criteria, and waiting lists to ensure that families are referred to other available publicly-funded early childhood programs should they be ineligible for or unable to access their primary choice;
3. a coordinated application process through which the community network conducts a unified application process so families can easily indicate their enrollment choices for publicly-funded programs; and
4. a matching based on family preference through which the community network enrolls at-risk children, using available public funds and based upon stated family preferences.

C. In collaboration with representatives of providers of child care, Head Start, and prekindergarten services, the lead agency shall develop policies and procedures for how the requirements of §703.B will be implemented. These policies and procedures shall be submitted to the department prior to initiation of the enrollment process.

D. Each community network shall operate a coordinated enrollment process for each school year, subject to the implementation timeline provided in §705.

E. The lead agency shall ensure the community network develops and implements a process to enroll publicly-funded children on an ongoing basis outside of the community network's established application period each year.

F. Any publicly-funded program that seeks to enroll children outside of their community network's coordinated enrollment process shall obtain prior written approval from the department.

G. Request for Departmental Review

1. Any parent or caregiver may request that the department review the placement of his or her child resulting from the coordinated enrollment process.

2. A request for departmental review shall be submitted in writing to the department within 15 calendar days of placement of the child or of the event upon which the request for review is based.

3. All requests for departmental review shall clearly state the specific reasons for requesting the review and the action being sought, and shall include all necessary supporting documentation.

4. The department shall respond to the request for departmental review within 30 calendar days after receiving it.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21, et seq. and R.S. 17:407:91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§705. Implementation Timeline

A. Community networks that began receiving funding prior to January 2015 shall develop and implement all four components of the coordinated enrollment process as defined in §703 during the 2015-2016 school year for use in enrollment that begins with the 2016-2017 school year.

B. Community networks that began receiving funding on or after January 2015 shall develop and implement all four components of the coordinated enrollment process as defined in §703 during the 2015-2016 and 2016-2017 school years for use in enrollment that begins with the 2017-2018 school year.

1. Community networks shall establish the coordinated information campaign, coordinated eligibility determination and coordinated application process as defined in §703.B.1-B.3 during the 2015-2016 school year for enrollment that begins with the 2016-2017 school year.

C. The state superintendent, pursuant to authority delegated by BESE, may grant a community network a one year extension of time to develop and implement the enrollment process.

1. Any community network that began receiving funding prior to January 2015 requesting an extension of time shall submit a written request to the department no later than December 1, 2015.

2. Any community network that began receiving funding on or after January 2015 requesting an extension of time shall submit a written request to the department no later than February 1, 2016.

3. The request shall include written justification of the need for the extension and an assurance that families will be informed of the enrollment process for all publicly-funded programs in the community network.

4. The state superintendent, or designee, shall respond in writing to a request within 30 calendar days of receipt of the request.

D. Community networks shall determine preliminary eligibility for families interested in CCAP during the coordinated eligibility determination as provided in §703.B.2 and the department shall determine final eligibility for CCAP.

E. Prior to the start of the 2016-2017 school year, BESE shall review this Chapter and revise as necessary based on learnings from the 2015-2016 learning year. A work group of the Early Childhood Care and Education Advisory Council shall be formed to study the effectiveness of the coordinated enrollment process conducted in the learning year and make recommendations to the council and BESE for changes for

implementation in 2016-2017. This research should include, but not be limited to, conducting focus groups of all provider types, reviewing data on the placement of new early childhood seats opened statewide, and reviewing other available information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq., and R.S. 17:407.91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§707. Demonstrated Progress Toward Implementation

A. No later than August 31, 2015, each community network shall submit a self-assessment of its progress toward full implementation of each component of the coordinated enrollment process as defined in §703.B.

B. The department may require community networks to complete an enrollment self-assessment each year.

C. The lead agency of any community network not making progress on coordinated enrollment, or not achieving the full coordinated enrollment process according to the timeline in §705, may be subject to BESE intervention, as specified in §711.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§709. Community Network Request for Funding for Publicly-Funded Programs

A. By March 31 of each fiscal year, the lead agency shall develop, in collaboration with representatives of providers of child care, Head Start, and prekindergarten services, and submit a funding request for the following fiscal year to the department on behalf of the community network that is based on the coordinated enrollment results, which shall include the following:

1. the number of applications received for each age of at-risk children;
2. the number of seats requested at each publicly-funded site;
3. the number of seats recommended by the lead agency to receive funding with a prioritization by site and age of children served by funding source;
4. the recommended plan to maximize all funding sources to increase service to at-risk children; and
5. the number of seats being requested in a mixed delivery setting.

B. The lead agency shall provide an opportunity for each publicly-funded program in the community network and the general public in the coverage area of the community network to comment on the proposed funding request prior to submission to the department and shall include documentation of this process in the funding request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq., and R.S. 17:407.91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§711. Local Enrollment Coordinator

A. If the lead agency is not satisfactorily coordinating the duties and responsibilities of the community network pertaining to the community network's coordinated enrollment process, the department shall send written notification to the lead agency and all programs within the community network. The written notification shall identify

the unsatisfactory performance issues and specify any corrective actions that may be required of the lead agency.

B. Within 30 calendar days of receiving such notice, the lead agency shall submit written certification to the department that corrective actions have been taken or are in the process of being taken and submit a timely implementation schedule for the department's approval.

C. If the lead agency does not respond in a timely or satisfactory manner or adhere to the implementation schedule approved by the department, the department may recommend that BESE terminate the lead agency's duties and responsibilities pertaining to coordinated enrollment and authorize a local enrollment coordinator for the community network.

D. A local enrollment coordinator is an entity authorized by BESE to assume responsibility for the services a lead agency is required to provide in coordinating the community network's coordinated enrollment process, as set forth in §309.B.1.b and §§703-709.

1. A local enrollment coordinator may be a state agency, including the department, a public school system, a nonprofit or for-profit corporation having an educational or social services mission, including but not limited to a nonprofit corporation of a philanthropic or policy nature, a Louisiana postsecondary education institution, or a nonprofit corporation established by the governing authority of a parish or municipality.

2. A local enrollment coordinator shall be authorized for a term no greater than five years.

3. A local enrollment coordinator authorized by BESE shall enter into a local enrollment coordinator agreement with the department.

4. If a local enrollment coordinator is authorized, the lead agency's allocation shall be reduced by, or the lead agency shall repay, an amount equal to that portion of the coordinated enrollment duties and responsibilities that remain outstanding.

E. If BESE terminates a lead agency's responsibilities pertaining to coordinated enrollment, but does not terminate the lead agency's approval to serve as the lead agency for the community network, the lead agency shall continue to serve as lead agency and coordinate all other duties and responsibilities of the community network.

F. Funding

1. For each local enrollment coordinator authorized by BESE, the department shall allocate not more than one percent of the public funds appropriated for each publicly-funded program in the community network to support the local enrollment coordinator.

2. The amount allocated from the funding for each publicly-funded site shall be proportionate to the number of publicly-funded children in the site enrolled by the local enrollment coordinator.

3. If an allocation cannot be made from a funding source to support the local enrollment coordinator, the amount established for that funding source to support the local enrollment coordinator shall be allocated from the remaining public funding sources in an amount proportionate to the number of children in each publicly-funded program enrolled by the local enrollment coordinator.

4. BESE shall not allocate additional funds to support local enrollment coordinators from any public funding source that has a per-child allocation or subsidy below the Louisiana average per-child allocation or subsidy for all programs included in the enrollment system.

G. Audit

1. A local enrollment coordinator shall annually submit to the department an independent financial audit conducted by a certified public accountant who has been approved by the legislative auditor. Such audit shall be accompanied by the auditor's statement that the report is free of material misstatements. The audit shall be limited in scope to those records necessary to ensure that the local enrollment coordinator has used funds to perform required services, and it shall be submitted to the legislative auditor for review and investigation of any irregularities or audit findings.

2. The local early learning enrollment coordinator shall return to the state any funds that the legislative auditor determines were expended in a manner inconsistent with Louisiana law or BESE regulations.

3. The cost of such audit shall be paid by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq., and R.S. 17:407.91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§713. Request for Departmental Review

A. Any publicly-funded program may request that the department review an enrollment decision or funding request of its lead agency or local enrollment coordinator.

B. A request for departmental review shall be submitted in writing to the department no later than 10 calendar days after the day on which community networks must submit funding requests to the department or the day in which the community network submitted the funding request to the department, whichever is later.

C. All requests for departmental review shall clearly state the specific reasons for requesting the review and the action being sought, and shall include necessary supporting documentation.

D. The department shall respond to the request for review within 30 calendar days after receiving the request or prior to BESE considering funding allocations, whichever is sooner.

E. No publicly-funded program or community network may request departmental review of the funding allocation approved by BESE.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:407.21 et seq., and R.S. 17:407.91 et seq.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Family Impact Statement

In accordance with section 953 and 974 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.

2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.

3. Will the proposed Rule affect the functioning of the family? No.

4. Will the proposed Rule affect family earnings and family budget? No.

5. Will the proposed Rule affect the behavior and personal responsibility of children? No.

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2015, to Shan N.

Shan N. Davis
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Bulletin 140—Louisiana Early
Childhood Care and Education Network**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The proposed rule will result in an increase in expenditures by the Department of Education (DOE). There will also be an indeterminable increase in the expenditures of local school boards as a result of the proposed changes. The Early Childhood program is currently funded with federal block grant funds and state matching funds. While these funds may be used for expenses associated with the implementation of the new requirements defined in the proposed rules, they may be insufficient to fully fund actual costs. Therefore, local entities acting as lead agencies will be expected to identify and leverage existing and additional resources as needed. Furthermore, while the rules establish an accountability system, 2015-2016 will serve as a learning year; any potential incentives or sanctions associated with the performance expectations will be defined in future rule changes and resulting fiscal implications are indeterminable at this time.

The purpose of Bulletin 140 is to establish the duties and responsibilities of the Early Childhood Care and Education Network, local community networks and community network lead agencies, define kindergarten readiness, and create a uniform assessment and accountability system for publicly-funded early childhood care and education sites and community networks that includes a performance profile indicative of performance.

The bulletin defines community networks and lead agencies within each network, and outlines the responsibilities and accountability standards for each. The lead agencies may be local school districts or other local government entities. The lead agencies and community networks are allocated funds for these duties, which include classroom observations, student assessments, the implementation of a coordinated enrollment process and annual reporting to the Department of Education (DOE). Activities are funded from multiple sources including federal Child Care and Development Funds (CCDF), federal IDEA funds, state general funds, as well as local funding and other available resources. Lead agencies shall work with all publicly funded programs within the network to maximize all available resources to increase the access to and quality of the programs. Initial allocations include funds to cover start-up costs and recurring funding will be allocated for classroom observations. The current \$200 per observation allocation is an estimate based on reports from the pilot community networks over the last two years. In the event state funding allocations are less than actual expenses, school districts acting as lead agencies will also have to use local funds or other resources in order to meet the requirements delineated in the rules. The LDOE anticipates that the coordinated enrollment system will utilize existing staff from all sites participating in the network and may not require additional funding, rather could allow for certain efficiencies through shared resources. However, this will not always be the case and there will be an increase in expenditures for some networks, including those choosing to develop an online enrollment system.

All publicly funded sites are to ensure that all children receive assessments throughout the year. The DOE currently provides funding for the cost of these assessments. Furthermore, the DOE will conduct an annual review of all publicly funded programs using a third party contractor. The DOE will also use a contractor to audit a lead agency or to act as a lead agency in the event an existing entity is disqualified.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE
OR LOCAL GOVERNMENTAL UNITS (Summary)**

This policy will have no effect on revenue collections of state or local governmental units.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL
GROUPS (Summary)**

A lead agency may also be a non-profit or or-profit corporation. As such the implementation costs and allocations for lead agencies described above in Section I will apply to these non-governmental groups.

The coordinated enrollment system may result in savings for parents if they are able to place their children in less expensive childcare centers since the enrollment system may make them aware of cheaper options. In future years, the accountability system and adjustments to funding could affect the number and/or the capacity of providers; operating costs for providers as well as child care costs and options for parents.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1509#041

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for School
Administrators (LAC 28: CXV.701, 1103, 2319, and 2363)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 741—Louisiana Handbook for School Administrators*: §701, Maintenance and Use of System Records and Reports; §1103, Compulsory Attendance; §2319, The Career Diploma; and §2363, Social Studies. The proposed policy revisions are required by legislation passed during the 2015 Regular Legislative Session and to correct an omission.

Title 28

EDUCATION

**Part CXV. Bulletin 741—Louisiana Handbook for
School Administrators**

Chapter 7. Records and Reports

**§701. Maintenance and Use of System Records and
Reports**

A. - B.2. ...

3. By not later than May 1, 2015, the LDE shall develop a system of unique student identification numbers. By not later than August 1, 2015, each local public school board shall assign such a number to every student enrolled in a public elementary or secondary school. Student identification numbers shall not include or be based on

social security numbers, and a student shall retain his student identification number for his tenure in Louisiana public elementary and secondary schools.

4. Information files and reports shall be stored with limited accessibility and shall be kept reasonably safe from damage and theft.

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:93; R.S. 17:411; R.S. 17:415, R.S. 17: 3913

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1268 (June 2005), amended LR 37:1380, 1380 (May 2011), LR 40:764 (April 2014), LR 41:41 (January 2015), LR 41:

Chapter 11. Student Services

§1103. Compulsory Attendance

A. ...

B. A parent, tutor, or legal guardian who has a student who is under the age of 18 and meets one of the requirements below shall be in compliance with the compulsory attendance law.

1. A student, under 18 years of age, who withdraws from school prior to graduating from high school, who has not enrolled in a dropout recovery program as provided in R.S. 17:221.6, and who has been ruled to be a truant, pursuant to the provisions of chapter 15 of title VII of the *Louisiana Children's Code*, by a court of competent jurisdiction can be ordered by the court to exercise one of the following options within 120 days of leaving school:

a. reenroll in school and make continual progress toward completing the requirements for high school graduation;

b. enroll in a high school equivalency diploma program and make continual progress toward completing the requirements for earning such diploma;

c. enlist in the Louisiana National Guard or a branch of the United States Armed Forces, with a commitment for at least two years of service, and earn a high school equivalency diploma during such service period.

B.2. - N. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:112, R.S. 17:221.3-4, R.S. 17:226.1, and R.S. 17:233.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1273 (June 2005), amended LR 32:546 (April 2006), LR 32:1030 (June 2006), LR 33:2351 (November 2007), LR 35:641 (April 2009), LR 35:1097 (June 2009), LR 35:1475 (August 2009), LR 36:482 (March 2010), LR 36:1224 (June 2010), LR 37:1126 (April 2011), LR 37:2132 (July 2011), LR 38:1000 (April 2012), LR 38:1225 (May 2012), LR 38:1399 (June, 2012), LR 39:2205 (August 2013), LR 41:372 (February 2015), LR 41:

Chapter 23. Curriculum and Instruction

Subchapter A. Standards and Curricula

§2319. The Career Diploma

A. - C.2.a.iii.(f). ...

b. mathematics—4 units:

i. algebra I, applied algebra I, or algebra I-Pt. 2 (the elective course algebra I-Pt. 1 is a pre-requisite);

ii. The remaining units shall come from the following:

- (a). geometry;
- (b). financial literacy (formerly financial math);
- (c). math essentials;
- (d). algebra II;
- (e). advanced math-functions and statistics;

(f). advanced math-pre-calculus;

(g). algebra III;

(h). pre-calculus;

(i). business math

(j). comparable Louisiana technical college courses offered by Jump Start regional teams as approved by BESE;

(k). integrated mathematics I, II, and III may be substituted for algebra I, geometry, and algebra II and shall count as 3 math credits;

2.c. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:24.4, R.S. 17:183.2, R.S. 17:183.3, R.S. 17:274, R.S. 17:274.1, and R.S. 17:395.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1291 (June 2005), amended LR 31:2211 (September 2005), LR 31:3070 (December 2005), LR 31:3072 (December 2005), LR 32:1414 (August 2006), LR 33:429 (March 2007), LR 33:432 (March 2007), LR 33:2050 (October 2007), LR 33:2354 (November 2007), LR 33:2601 (December 2007), LR 34:1607 (August 2008), LR 35:1230 (July 2009), LR 35:1876 (September 2009), LR 35:2321 (November 2009), LR 35:2750 (December 2009), LR 36:1490 (July 2010), LR 37:548 (February 2011), LR 37:1130 (April 2011), LR 37:2130 (July 2011), LR 37:3197 (November 2011), LR 38:761 (March 2012), LR 38:1005 (April 2012), LR 40:2522 (December 2014), LR 41:

Subchapter B. Academic Programs of Study

§2363. Social Studies

A. - D.4. ...

E. Beginning with the 2016-2017 school year, the civics course and all courses permitted to substitute for civics, shall contain a unit of study that includes the civics-related content of which naturalized citizens are required to demonstrate mastery.

1. Students shall be administered a test based on the content of the civics portion of the naturalization test used by the United Citizenship and Immigration Services.

2. Courses permitted to substitute for civics include the following:

- a. American government;
- b. AP U.S. government and politics: comparative;
- c. AP U.S. government and politics: U.S.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:24.4, R.S. 17:183.3, R.S. 17:274, R.S. 17:274.1, and R.S. 17:274-274.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1298 (June 2005), amended LR 31:3072 (December 2005), LR 33:431 (March 2007), LR 33:2606 (December 2007), LR 36:1495 (July 2010), LR 37:1131 (April 2011), LR 40:1000 (May 2014), LR 40:2529 (December 2014), LR 41:

Family Impact Statement

In accordance with section 953 and 974 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.

2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.

3. Will the proposed Rule affect the functioning of the family? No.

4. Will the proposed Rule affect family earnings and family budget? No.

5. Will the proposed Rule affect the behavior and personal responsibility of children? No.

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2015, to Shan N. Davis, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Bulletin 741—Louisiana Handbook for School Administrators**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed policy revision will have no effect on costs or savings to state or local governmental units.

The revision to §701 aligns with Act 228 (2015) which updates the law enacted in 2014 placing limitations on the sharing of personally identifiable student data with an effective date of August 1, 2015. Act 392 (2015) authorizes all public school systems to establish dropout recovery programs. The revision to §1103 clarifies that students enrolled in a dropout recovery program are in compliance with compulsory attendance laws. The revision to §2319 updates the list of mathematics courses accepted for the Career Diploma to include Business Math. Business Math is included in the list of accepted courses in R.S. 17:183.3, but was erroneously omitted from BESE policy. The revision to §2363 is required by Act 469 (2015) which requires Civics courses to contain a unit that includes the civics-related content that naturalized citizens are required to know and requires that all Civics students take a test on this content.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

This policy will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1509#042

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Student Financial Assistance Commission Office of Student Financial Assistance

TOPS GPA Calculation (LAC 28:IV.705, 803 and 805)

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its scholarship/grant rules (R.S. 17:3021-3025, R.S. 3041.10-3041.15, R.S. 17:3042.1, R.S. 17:3048.1, R.S. 17:3048.5 and R.S. 17:3048.6).

This rulemaking amends the administrative rules to provide that students will have until the end of the academic year to achieve the cumulative grade point average required by their award.

It also provides that high school graduates through the 2016-2017 academic year may utilize the core curriculum that was in effect prior to the passage of Act 403 during the 2015 Regular Session of the Louisiana Legislature. (SG16165NI)

**Title 28
EDUCATION**

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

**Chapter 7. Taylor Opportunity Program for Students
(TOPS) Opportunity, Performance, and
Honors Awards**

§705. Maintaining Eligibility

A. - A.7. ...

8.a. Through the 2013-14 academic year (TOPS), maintain at an eligible college or university, by the end of the spring semester, quarter, or term, a TOPS cumulative college grade point average on a 4.00 maximum scale of at least:

i. a 2.30 with the completion of 24 but less than 48 credit hours, a 2.50 after the completion of 48 credit hours, for continuing receipt of an Opportunity Award, if enrolled in an academic program; or

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

b. Beginning with the 2014-15 academic year (TOPS), maintain at an eligible college or university, by the end of the academic year, a TOPS cumulative college grade point average on a 4.00 maximum scale of at least:

i. a 2.30 with the completion of 24 but less than 48 credit hours, a 2.50 after the completion of 48 credit hours, for continuing receipt of an Opportunity Award, if enrolled in an academic program; or

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

c. The provisions of §705.A.8.b shall not apply during the 2014-2015 academic year to students who met the requirements of §705.A.7 at the end of the spring semester of 2015, but who did not meet the requirements of §705.A.8.b. at the end of the 2014-2015 academic year.

d. Beginning with the 2015-16 academic year (TOPS), maintain at an eligible college or university, by the end of the academic year, a TOPS cumulative college grade point average (Opportunity, Performance, Honors) on a 4.00 maximum scale of at least:

i. a 2.30 with 24 but less than 48 earned credit hours for continuing receipt of an Opportunity Award, if enrolled in an academic program for the last semester attended during the academic year; or

ii. a 2.50 with 24 but less than 48 earned credit hours for continuing receipt of an Opportunity Award, if enrolled in a program for a vocational or technical education certificate or diploma or a non-academic undergraduate degree for the last semester attended during the academic year; or

iii. a 2.50 with 48 or more earned credit hours for continuing receipt of an Opportunity Award, if enrolled in any program of study for the last semester attended during the academic year; and

e. a 3.00 for continuing receipt of either a Performance or Honors Award; or

f. the minimum grade necessary to maintain good standing, if enrolled in a graduate or professional program; or

g. meet the federal grant aid steady academic progress requirement at that school, if enrolled in an eligible cosmetology or proprietary school; and

B.1. Students failing to meet the requirements listed in §705.A.7 or §705.A.8.a., b, d, f, or g may have their tuition awards reinstated upon regaining “steady academic progress” (see §301) and/or attainment of the required TOPS cumulative grade point average, if the period of ineligibility did not persist for more than two years from the date of loss of eligibility.

2. If the two-year period is interrupted due to a student's active duty in the United States Armed Forces, the two-year period will be extended for a length of time equal to the student's active duty service.

3. Students who fail to meet the requirements of §705.A.8.d, shall no longer be eligible for the stipend authorized for the Performance and Honors Awards, but shall be eligible to receive the award amount for the Opportunity Award if they meet the continuation requirements of §705.A.8.a, b, d, f, or g.

4.a. A student shall have one semester or quarter after the 2015-16 academic year (TOPS) for which the TOPS Award will be paid to meet the requirements of §705.A.8.d if the student:

i. failed to meet the requirements listed in §705.A.8.d solely because the calculation of the TOPS cumulative grade point average (Opportunity, Performance, Honors) at the end of the 2015- 2016 academic year (TOPS) includes both hours and grades for courses taken before the 2015-16 academic year (TOPS) in both academic and technical courses of study; and

ii. was a high school graduate or home study completer who enrolled for the first time as a full-time student in an eligible postsecondary institution before the 2015-16 academic year (TOPS); and

iii. not suspended after the 2014-15 academic year (TOPS).

b. The TOPS award of a student who meets the requirements of §705.B.4.a shall not be suspended unless the student fails to meet the requirements of §705.A.8.d by the end of the fall semester or quarter of 2016 in which case:

i. the student's TOPS award shall be suspended effective at the end of the fall semester or quarter of 2016; and

ii. the provisions of §705.B.1 and 2 shall apply.

c. If a student does not enroll full time for the fall semester or quarter of 2016 and any subsequent consecutive semesters or quarters and is granted an exception for all of those semesters or quarters, the provisions of §705.B.4.b shall be extended to the end of the next semester or quarter during which the student enrolls full time and for which the student's TOPS award is paid.

C. - F.2. ...

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

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

LR 22:338 (May 1996), repromulgated LR 24:637 (April 1998), amended LR 24:1904 (October 1998), LR 25:257 (February 1999), LR 25:656 (April 1999), LR 25:1091 (June 1999), LR 26:67 (January 2000), LR 26:688 (April 2000), LR 26:1996 (September 2000), LR 26:2001 (September 2000), repromulgated LR 27:1853 (November 2001), amended LR 28:447 (March 2002), LR 28:772 (April 2002), LR 28:2332 (November 2002), LR 29:2373 (November 2003), LR 30:781 (April 2004), LR 30:1163 (June 2004), LR 30:2019 (September 2004), LR 31:3115 (December 2005), LR 33:437 (March 2007), LR 34:1390 (July 2008), LR 36:491 (March 2010), LR 36:2856 (December 2010), LR 38:3159 (December 2012), LR 40:1002 (May 2014), LR 41:664 (April 2015), LR 41:

Chapter 8. TOPS-Tech Award
§803. Establishing Eligibility

A. - A.6.a.iv. ...

v. for students graduating in the 2013-2014 school year through the 2016-2017 school year, the high school course work documented on the student's official transcript as approved by the Louisiana Department of Education constituting the following TOPS-Tech core curriculum;

Core Curriculum—TOPS-Tech Award	
Units	Course
1	English I
1	English II
1	English III
1	English IV or substitute 1 unit of Business English
1	Algebra I; or both Algebra I, Part 1 and Algebra I, Part 2; or both Applied Mathematics I and Applied Mathematics II
2	Geometry, Applied Mathematics III, Algebra II, Financial Mathematics, Advanced Mathematics I [beginning with the 2008-2009 academic year (high school) this course is renamed Advanced Math – Pre-Calculus], Advanced Mathematics II [beginning with the 2008-2009 academic year (high school) this course is renamed Advanced Math – Functions and Statistics], Discrete Mathematics, or Probability and Statistics (2 units). Integrated Mathematics I, II, and III may be substituted for Algebra I, Geometry and Algebra II, and shall be considered the equivalent of the 3 required math units
1	Biology
2	Earth Science, Environmental Science, Physical Science, Integrated Science, Biology II, or Chemistry or Applied Chemistry, Chemistry II, Physics, Physics II or Physics for Technology or Agriscience I and II (both for 1 unit)
1	American History
1	World History, Western Civilization or World Geography
1	Civics and Free Enterprise (1 unit combined) or Civics (1 unit, non-public)
Remaining Core Courses Shall Be Selected from One of the Following Options	
Option 1—Total of 17 Units	
1	Fine Arts Survey or drafting (one unit) or substitute 2 units of performance courses in music, dance, or theater; or substitute 2 units of visual art courses; or substitute 2 units of studio art courses; or a course from the Career and Technical Program of studies that is approved by the BESE (must be listed under the Vocational Education Course Offerings in Bulletin 741 or the updates to Bulletin 741); or substitute 1 unit as an elective from among the other subjects listed in this core curriculum
2	Foreign Language, Technical Writing, Speech I or Speech II
1	One unit from the secondary computer education program of studies that is approved by the BESE
or	
Option 2—Total of 19 Units	
4	In a career major comprised of a sequence of related specialty courses. In order for a student to use this option, the courses for the career major must be approved by BESE.
1	Credit in a basic computer course

Core Curriculum—TOPS-Tech Award	
Units	Course
1	In related or technical fields. A related course includes any course which is listed under the student's major. A technical course is one that is listed in the approved career option plan for the high school at which the course is taken.

A.6.b. - B.4.b.ii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3025, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:1904 (October 1998), amended LR 24:2237 (December 1998), LR 25:1795 (October 1999), LR 26:65 and 67 (January 2000), LR 26:1602 (August 2000), LR 26:1997 (September 2000), LR 26:2269 (October 2000), LR 26:2754 (December 2000), LR 27:36 (January 2001), LR 27:1220 (August 2001), repromulgated LR 27:1854 (November 2001), amended LR 28:447 (March 2002), LR 28:773 (April 2002), LR 28:2330 (November 2002), LR 29:554 (April 2003), LR 30:1164 (June 2004), LR 30:2019 (September 2004), LR 31:39 (January 2005), LR 31:3114 (December 2005), LR 33:437 (March 2007), LR 33:2614 (December 2007), LR 35:230 (February 2009), LR 36:491 (March 2010), LR 36:2270 (October 2010), LR 36:2856 (December 2010), LR 38:3159 (December 2012), LR 41:654 (April 2015), LR 41:

§805. Maintaining Eligibility

A. - A.6. ...

7.a. through the 2013-14 academic year, maintain, by the end of the spring term, a TOPS cumulative college grade point average (TOPS Tech) of at least 2.50 on a 4.00 maximum scale, provided that this requirement does not apply to a student who is enrolled in a cosmetology or proprietary school that is an eligible college or university and the student has met the federal grant aid steady academic progress requirement at that school; and

b. beginning with the 2014-15 academic year, maintain, by the end of the academic year, a TOPS cumulative college grade point average (TOPS Tech) of at least 2.50 on a 4.00 maximum scale, provided that this requirement does not apply to a student who is enrolled in a cosmetology or proprietary school that is an eligible college or university and the student has met the federal grant aid steady academic progress requirement at that school; and

A.8. - E. ...

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

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:1905 (October 1998) amended LR 25:1091 (June 1999), LR 26:68 (January 2000), LR 26:689 (April 2000), LR 26:1997, 2002 (September 2000), repromulgated LR 27:1856 (November 2001), amended LR 28:774 (April 2002), LR 28:2332 (November 2002), LR 29:880 (June 2003), LR 29:2373 (November 2003), LR 30:781 (April 2004), LR 30:1165 (June 2004), LR 30:2019 (September 2004), LR 31:3115 (December 2005), LR 33:438 (March 2007), LR 35:1489 (August 2009), LR 38:3160 (December 2012), LR 40:1002 (May 2014), LR 41:666 (April 2015), LR 41:

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

Provider Impact Statement

The proposed Rule will have no adverse impact on providers of services for individuals with developmental disabilities as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments on the proposed changes (SG16165NI) until 4:30 p.m., October 12, 2015, by email to LOSFA.Comments@la.gov or to Sujuan Williams Boutté, Ed. D., Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

Robyn Rhea Lively
Senior Attorney

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: TOPS GPA Calculation

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule changes move the annual cumulative college GPA checks from the end of the Spring Term to the end of the college academic year, thus including any grades earned during summer session. As a result of the proposed changes, it is estimated that approximately 38 students will retain their eligibility for Performance or Honors Award stipends and that approximately 33 additional TOPS Tech students will receive funding for Summer Term attendance for each year beginning in FY 16. The total annual cost for each of these years is not expected to exceed \$50,000.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no impact on state or local governmental revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There is no significant impact on directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected by the proposed change.

Robyn Rhea Lively
Senior Attorney
1509#019

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Environmental Quality Office of the Secretary Legal Division

Cathode Ray Tubes (CRT)
(LAC 33:109, 4911, and 4915)(HW116ft)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Hazardous Waste regulations, LAC 33:109, 4911, and 4915 (Log #HW116ft).

This Rule is identical to federal regulations found in 79 FR 123, which are applicable in Louisiana. For more information regarding the federal requirement, contact the Regulation Development Section at (225) 219-3985 or P.O. Box 4302, Baton Rouge, LA 70821-4302. No fiscal or economic impact will result from the Rule. This Rule will be promulgated in accordance with the procedures in R.S. 49:953(F)(3) and (4).

This Rule adopts changes to export provisions in the federal cathode ray tube (CRT) disposal regulation in Louisiana. Louisiana's hazardous waste program operates under a federal grant from the EPA. Part of the requirements for this grant is to be equivalent to or more stringent than the corresponding federal regulations. The basis and rationale are to mirror federal regulations. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part V. Hazardous Waste and Hazardous Materials

Subpart 1. Department of Environmental Quality— Hazardous Waste

Chapter 1. General Provisions and Definitions

§109. Definitions

For all purposes of these rules and regulations, the terms defined in this Chapter shall have the following meanings, unless the context of use clearly indicates otherwise.

* * *

CRT Exporter—any person in the United States who initiates a transaction to send used CRTs outside the United States or its territories for recycling or reuse, or an intermediary in the United States arranging for such export.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 10:200 (March 1984), amended LR 10:496 (July 1984), LR 11:1139 (December 1985), LR 12:319 (May 1986), LR 13:84 (February 1987), LR 13:433 (August 1987), LR 13:651 (November 1987), LR 14:790, 791 (November 1988), LR 15:378 (May 1989), LR 15:737 (September 1989), LR 16:218, 220 (March 1990), LR 16:399 (May 1990), LR 16:614 (July 1990), LR 16:683 (August 1990), LR 17:362 (April 1991), LR 17:478 (May 1991), LR 18:723 (July 1992), LR 18:1375 (December 1992), repromulgated by the Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 19:626 (May 1993), amended LR 20:1000 (September 1994), LR 20:1109 (October 1994), LR 21:266 (March 1995), LR 21:944 (September 1995), LR 22:814 (September 1996), LR 23:564 (May 1997), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:655 (April 1998), LR 24:1101 (June 1998), LR 24:1688 (September 1998), LR 25:433 (March 1999), repromulgated LR 25:853 (May 1999), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:269 (February 2000), LR 26:2465 (November 2000), LR 27:291 (March 2001), LR 27:708 (May 2001), LR 28:999 (May 2002), LR 28:1191 (June 2002), LR 29:318 (March 2003); amended by the Office of the Secretary, Legal Affairs Division, LR 31:2452 (October 2005), LR 31:3116 (December 2005), LR 32:606 (April 2006), LR 32:822 (May 2006), LR 33:1625 (August 2007), LR 33:2098 (October 2007), LR 34:71 (January 2008), LR 34:615 (April 2008), LR 34:1009 (June 2008), LR 34:1894 (September 2008), LR 34:2396 (November 2008), LR

36:1235 (June 2010), repromulgated LR 36:1535 (July 2010), amended LR 36:2554 (November 2010), LR 38:774, 781 (March 2012), repromulgated LR 38:1009 (April 2012), amended by the Office of the Secretary, Legal Division, 40:1338 (July 2014), LR 41:

Chapter 49. Lists of Hazardous Wastes

§4911. Conditional Exclusion for Used, Broken Cathode Ray Tubes (CRTs) Undergoing Recycling

A. - A.4. ...

5. Exports

a. In addition to the applicable conditions specified in Paragraphs A.1-4 of this Section, exports of used, broken CRTs must comply with the following requirements.

i. Notify EPA of an intended export before the CRTs are scheduled to leave the United States. A complete notification should be submitted 60 days before the initial shipment is intended to be shipped off-site. This notification may cover export activities extending over a 12-month period. The notification must be in writing, signed by the exporter, and include:

(a). name, mailing address, telephone number, and EPA ID number (if applicable) of the exporter of the CRTs;

(b). the estimated frequency or rate at which the CRTs are to be exported and the period of time over which they are to be exported;

(c). the estimated total quantity of CRTs specified in kilograms;

(d). all points of entry to, and departure from, each foreign country through which the CRTs will pass;

(e). a description of the means by which each shipment of the CRTs will be transported (e.g., mode of transportation vehicle (air, highway, rail, water, etc.), and type(s) of container used (drums, boxes, tanks, etc.);

(f). the name and address of the recycler(s), the estimated quantity of used CRTs to be sent to each facility, and the names of any alternate recyclers;

(g). a description of the manner in which the CRTs will be recycled in the foreign country that will be receiving the CRTs; and

(h). the name of any transit country through which the CRTs will be sent, and a description of the approximate length of time the CRTs will remain in such country and the nature of their handling while there.

ii. Notifications submitted by mail should be sent to the following mailing address: Office of Enforcement and Compliance Assurance, Office of Federal Activities, International Compliance Assurance Division (Mail Code 2254A), Environmental Protection Agency, 1200 Pennsylvania Avenue, NW, Washington, DC 20460. Hand-delivered notifications should be sent to: Office of Enforcement and Compliance Assurance, Office of Federal Activities, International Compliance Assurance Division, (Mail Code 2254A), Environmental Protection Agency, Ariel Rios Bldg., Room 6144, 1200 Pennsylvania Ave., NW, Washington, DC. In both cases, the following shall be prominently displayed on the front of the envelope: "Attention: Notification of Intent to Export CRTs."

iii. Upon request by EPA, the exporter shall furnish to EPA any additional information which a receiving country requests in order to respond to a notification.

iv. EPA will provide a complete notification to the receiving country and any transit countries. A notification is complete when EPA receives a notification which EPA determines satisfies the requirements of Clause A.5.a.i of this Section. Where a claim of confidentiality is asserted with respect to any notification information required by Clause A.5.a.i of this Section, EPA may find the notification not complete until any such claim is resolved in accordance with 40 CFR 260.2.

v. The export of CRTs is prohibited unless the receiving country consents to the intended export. When the receiving country consents in writing to the receipt of the CRTs, EPA will forward an acknowledgment of consent to export CRTs to the exporter. Where the receiving country objects to receipt of the CRTs or withdraws a prior consent, EPA will notify the exporter in writing. EPA will also notify the exporter of any responses from transit countries.

vi. When the conditions specified on the original notification change, the exporter must provide EPA with a written renotification of the change, except for changes to the telephone number in Subclause A.5.a.i.(a) of this Section, and decreases in the quantity indicated in Subclause A.5.a.i.(c) of this Section. The shipment cannot take place until consent of the receiving country to the changes has been obtained (except for changes to information about points of entry and departure and transit countries pursuant to Subclauses A.5.a.i.(d) and A.5.a.i.(h) of this Section).

vii. A copy of the acknowledgment of consent to export CRTs must accompany the shipment of CRTs. The shipment must conform to the terms of the acknowledgment.

viii. If a shipment of CRTs cannot be delivered for any reason to the recycler or the alternate recycler, the exporter of CRTs must renotify EPA of a change in the conditions of the original notification to allow shipment to a new recycler in accordance with Subclause A.5.a.i.(f) of this Section, and obtain another acknowledgment of consent to export CRTs.

ix. Exporters must keep copies of notifications and acknowledgments of consent to export CRTs for a period of three years following receipt of the acknowledgment.

x. CRT exporters must file with EPA no later than March 1 of each year, an annual report summarizing the quantities (in kilograms), frequency of shipment, and ultimate destination(s) (i.e., the facility or facilities where the recycling occurs) of all used CRTs exported during the previous calendar year. Such reports must also include the following:

(a). the name, EPA ID number (if applicable), and mailing and site address of the exporter;

(b). the calendar year covered by the report; and

(c). a certification signed by the CRT exporter that states: "I certify under penalty of law that I have personally examined and am familiar with the information submitted in this and all attached documents and that, based on my inquiry of those individuals immediately responsible for obtaining this information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment."

xi. Annual reports must be submitted to the office specified in Clause A.5.a.ii of this Section. Exporters must keep copies of each annual report for a period of at least three years from the due date of the report.

B. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, Legal Affairs Division, LR 31:3122 (December 2005), amended LR 34:645 (April 2008), amended by the Office of the Secretary, Legal Division, LR 41:

§4915. Notification and Recordkeeping for Used, Intact Cathode Ray Tubes (CRTs) Exported for Reuse

A. Cathode ray tube (CRT) exporters who export used, intact CRTs for reuse must send a notification to EPA. This notification may cover export activities extending over a 12-month period.

1. The notification must be in writing, signed by the exporter, and include:

a. name, mailing address, telephone number, and EPA ID number (if applicable) of the exporter of the used, intact CRTs;

b. the estimated frequency or rate at which the used, intact CRTs are to be exported for reuse, and the period of time over which they are to be exported;

c. the estimated total quantity of used, intact CRTs specified in kilograms;

d. all points of entry to, and departure from, each transit country through which the used, intact CRTs will pass, a description of the approximate length of time the used, intact CRTs will remain in such country, and the nature of their handling while there;

e. a description of the means by which each shipment of the used, intact CRTs will be transported (e.g., mode of transportation vehicle (air, highway, rail, water, etc.), and type(s) of container used (drums, boxes, tanks, etc.));

f. the name and address of the ultimate destination facility or facilities where the used, intact CRTs will be reused, refurbished, distributed, or sold for reuse; and the estimated quantity of used, intact CRTs to be sent to each facility, as well as the name of any alternate destination facility or facilities;

g. a description of the manner in which the used, intact CRTs will be reused (including reuse after refurbishment) in the foreign country that will be receiving the used, intact CRTs; and

h. a certification signed by the CRT exporter that states: "I certify under penalty of law that the CRTs described in this notice are intact and fully functioning or capable of being functional after refurbishment and that the used CRTs will be reused or refurbished and reused. I certify under penalty of law that I have personally examined and am familiar with the information submitted in this and all attached documents and that, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment."

2. Notifications submitted by mail should be sent to the following mailing address: Office of Enforcement and Compliance Assurance, Office of Federal Activities, International Compliance Assurance Division, (Mail Code 2254A), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460. Hand-delivered notifications should be sent to: Office of Enforcement and Compliance Assurance, Office of Federal Activities, International Compliance Assurance Division, (Mail Code 2254A), Environmental Protection Agency, William Jefferson Clinton Building, Room 6144, 1200 Pennsylvania Ave. N.W., Washington, DC 20004. In both cases, the following shall be prominently displayed on the front of the envelope: "Attention: Notification of Intent to Export CRTs."

B. Persons who export used, intact CRTs for reuse must keep copies of normal business records, such as contracts, demonstrating that each shipment of exported used, intact CRTs will be reused. This documentation must be retained for a period of at least three years from the date the CRTs were exported. If the documents are written in a language other than English, CRT exporters of used, intact CRTs sent for reuse must provide both the original, non-English version of the normal business records as well as a third-party translation of the normal business records into English within 30 days upon request by EPA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq. and in particular R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, Legal Affairs Division, LR 34:645 (April 2008), amended by the Office of the Secretary, Legal Division, LR 41:

Family Impact Statement

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

This Rule has no known impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by HW116ft. Such comments must be received no later than October 28, 2015, at 4:30 p.m., and should be sent to Deidra Johnson, Attorney Supervisor, Office of the Secretary, Legal Division, P.O. Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to deidra.johnson@la.gov. The comment period for this Rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of HW116ft. This regulation is available on the Internet at www.deq.louisiana.gov/portal/tabid/1669/default.aspx.

Public Hearing

A public hearing will be held on October 28, 2015, at 1:30 p.m. in the Galvez Building, Room 1051, 602 North Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed

amendments. Should individuals with a disability need an accommodation in order to participate, contact Deidra Johnson at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 North Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

Herman Robinson, CPM
Executive Counsel

1509#028

NOTICE OF INTENT

Department of Environmental Quality Office of the Secretary Legal Division

Title I Modification (LAC 33:III.502)(AQ347)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Air regulations, LAC 33:III.502 (AQ347).

This rule will revise the definition of “title I modification” in LAC 33:III.502.A to clarify that, in the context of section 111 of the Clean Air Act, such modifications are limited to physical or operational changes to an existing facility. 40 CFR 70.7(e)(2)(i)(A)(5) states that minor permit modification procedures may be used only for those permit modifications that are “not modifications under any provision of title I of the Act.” However, neither 40 CFR 70 nor 40 CFR 71 defines “title I modification” or otherwise describes what constitutes a modification “under any provision of title I of the Act.”

LAC 33:III.502.A defines “title I modification,” in relevant part, as “any physical change or change in the method of operation of a stationary source which increases the amount of any regulated air pollutant emitted or which results in the emission of any regulated air pollutant not previously emitted” and which “will result in the applicability of a standard of performance for new stationary sources promulgated pursuant to section 111 of the Clean Air Act.”

This definition could be interpreted to include both the addition of a new affected facility to a stationary source and the modification of an existing facility at a stationary source. However, under 40 CFR 60.2 and 60.14, a modification is defined as any physical or operational change to an existing facility.

Therefore, consistent with the aforementioned provisions, this rule revision will clarify that “title I modifications,” in the context of section 111 of the Clean Air Act, are limited to physical or operational changes to an existing facility. The

basis and rationale for this rule are to clarify that “title I modifications,” in the context of section 111 of the Clean Air Act, are changes to existing facilities. This rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33 ENVIRONMENTAL QUALITY Part III. Air

Chapter 5. Permit Procedures

§502. Definitions

A. Except where specifically provided in another Section herein, the following definitions apply to terms used in this Chapter. Except as provided in this Chapter, terms used in this Chapter retain the definition provided them in LAC 33:III.111 or the Louisiana air quality regulations. Wherever provisions related to the Acid Rain Program are concerned, the definitions provided in 40 CFR Part 72 shall apply.

* * *

Title I Modification—any physical change or change in the method of operation of a stationary source which increases the amount of any regulated air pollutant emitted or which results in the emission of any regulated air pollutant not previously emitted and which meets one or more of the following descriptions.

a. The change will constitute a modification as described in 40 CFR 60.14 and therefore result in the applicability of a standard of performance for new stationary sources promulgated pursuant to section 111 of the Clean Air Act.

b. The change will result in a significant net emissions increase under the *prevention of significant deterioration (PSD) program*, as defined in LAC 33:III.509.B.

c. The change will result in a significant net emissions increase under the program for nonattainment new source review, as defined in LAC 33:III.504.

d. The change will result in the applicability of a maximum achievable control technology (MACT) determination pursuant to regulations promulgated under section 112(g) (modifications, hazardous air pollutants) of the Clean Air Act.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2445 (November 2000), LR 28:1950 (September 2002), amended by the Office of the Secretary, Legal Affairs Division, LR 36:2553 (November 2010), LR 37:1148 (April 2011), LR 37:1391 (May 2011), LR 41:

Family Impact Statement

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

This Rule has no known impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by AQ347. Such comments must be received no later than November 4, 2015, at 4:30 p.m., and should be sent to Deidra Johnson, Attorney Supervisor, Office of the Secretary, Legal Division, P.O. Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to deidra.johnson@la.gov. Copies of these proposed regulations can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of AQ347. These proposed regulations are available on the Internet at www.deq.louisiana.gov/portal/tabid/1669/default.aspx.

Public Hearing

A public hearing will be held on October 28, 2015, at 1:30 p.m. in the Galvez Building, Room 1051, 602 North Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Deidra Johnson at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

These proposed regulations are available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 North Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

Herman Robinson, CPM
Executive Counsel

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Title I Modification

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs or savings to state or local governmental units as a result of the proposed rule change. The proposed rule change will revise the definition of "Title I Modification" to clarify that, in the context of section 111 of the Clean Air Act, such modifications are limited to physical or operational changes to an existing facility. Title I modifications are any physical change or change in the method of operation of a stationary source which increases the amount of any regulated air pollutant emitted or which results in the emission of any regulated air pollutant not previously emitted and that meets one of the other conditions set forth in the Title I Modification definition (a-d).

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no estimated effect on revenue collections of state or local governmental units as a result of the proposed rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Owners or operators of Part 70 sources, such as mills and processing plants, seeking a permit modification will be

affected by the proposed rule change. In evaluating the requisite permit application, LDEQ will determine whether the change constitutes a "Title I Modification." If the permit application is determined to be a "Title I Modification," the permit revision must be processed using significant modification procedures that require a public comment period of at least 30 days and a 45-day EPA review period. If it is not determined to be a "Title I Modification," minor modification procedures may be utilized.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition or employment in the public or private sector as a result of the proposed rule change.

Herman Robinson, CPM
Executive Counsel
1509#029

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor Crime Victims Reparations Board

Compensation to Victims
(LAC 22:XIII.103, 301, 303, and 503)

In accordance with the provisions of R.S. 49:950 et seq., which is the Administrative Procedure Act, and R.S. 46:1801 et seq., which is the Crime Victims Reparations Act, the Crime Victims Reparations Board hereby gives notice of its intent to promulgate rules and regulations regarding the awarding of compensation to applicants. There will be no impact on family earnings or the family budget as set forth in R.S. 49:972.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part XIII. Crime Victims Reparations Board

Chapter 1. Authority and Definitions

§103. Definitions

A. ...

* * *

Claimant—a victim or a dependent of a deceased victim, or the legal representative of either, an intervenor, the healthcare provider who provides healthcare services associated with a forensic medical examination as defined in R.S. 15:622, or in the event of a death, a person who legally assumes the obligation or who voluntarily pays the medical or the funeral or burial expenses incurred as a direct result of the crime.

* * *

Healthcare Provider—either of the following:

a. a physician or other healthcare practitioner licensed, certified, registered or otherwise authorized to perform specified healthcare services consistent with state law;

b. a facility or institution providing healthcare services, including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting.

Healthcare Services—means services, including but not limited to items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease ancillary to a sexually-oriented offense.

Pecuniary Loss—amount of expense reasonably and necessarily incurred by reason of personal injury as a consequence of death, or a catastrophic property loss, and includes:

- a. for personal injury:
 - i. ...
 - ii. actual loss of past earnings and anticipated loss of future earnings because of a disability resulting from the personal injury; or the receipt of medically indicated services for a victim related to the personal injury.
- a.iii. - d. ...

* * *

Sexually-Oriented Criminal Offense—includes any offense listed as a sexual offense in R.S. 15:541(24).

Victim—

a. Any person who suffers personal injury, death, or catastrophic property loss as a result of a crime committed in this state and covered by this Chapter. This includes any person who is a victim of human trafficking as defined by R.S. 14:46.2, a victim of trafficking of children for sexual purposes as defined by R.S. 14:46.3, or a victim of any offense involving commercial sexual exploitation including but not limited to R.S. 14:81.1, 81.3, 82, 82.1, 82.2, 83, 83.1, 83.2, 83.3, 83.4, 84, 85, 86, 89.2, 194.1, 95 and 282.

b. - c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), LR 24:328 (February 1998), LR 25:26 (January 1999), LR 26:1019 (May 2000), LR 29:577 (April 2003), LR 31:1330 (June 2005), LR 32:242 (February 2006), LR 35:65 (January 2009), LR 37:1605 (June 2011), LR 41:

Chapter 3. Eligibility and Application Process

§301. Eligibility

A. Claimant Responsibility

- 1. ...
- 2. Applications
 - a. - b. ...
 - c. The application is only valid if the crime (not involving a sexually-oriented offense) resulting in personal injury, death, or catastrophic property loss was reported to the appropriate law enforcement officer within 72 hours after the date of the crime or within such longer period as the board determines is justified by the circumstances.

d. An adult victim of sexually-oriented criminal offense is not required to report the crime to any law enforcement officer in order to file an application. However, if the victim chooses to report the sexually-oriented criminal offense, then the victim may take up to a year from the date of the crime to report it.

e. If a victim chooses not to report the crime to a law enforcement officer, he or she must submit a certification from a healthcare provider or coroner that a forensic medical examination of the victim was conducted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:538 (May 1994), amended LR 22:709 (August 1996), LR 31:2009 (August 2005), LR 35:65 (January 2009), LR 36:2278 (October 2010), LR 37:1605 (June 2011), LR 41:1487 (August 2015), LR 41:

§303. Application Process

A. Claimant Responsibility

1. Applications for reparations must be submitted to the sheriff's office in the parish where the crime occurred except for claims involving an adult victim of a sexually-oriented criminal offense. Applications involving an adult victim of a sexually-oriented criminal offense are sent directly to the board office.

2. - 4. ...

5. All invoices, bills, etc. must indicate the victim/claimant as the guarantor, except for victims of a sexually-oriented criminal offense. Victims of a sexually-oriented criminal offense cannot be billed for costs associated with a forensic medical exam.

A.6. - D.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), LR 41:

Chapter 5. Awards

§503. Limits on Awards

A. General

1. - 2. ...

3. Ancillary medical expenses to a forensic medical examination shall not exceed one thousand dollars for each case.

B. - O.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), LR 24:328 (February 1998), LR 25:26 (January 1999), LR 26:1019 (May 2000), LR 29:577 (April 2003), LR 31:1330 (June 2005), LR 32:242 (February 2006), LR 35:65 (January 2009), LR 37:1605 (June 2011), LR 39:1042 (April 2013), LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule has been considered. This proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972 since it only expands the definition of a crime victim who becomes eligible for reparations.

Poverty Impact Statement

The proposed Rule should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

- 1. the effect on household income, assets, and financial security;
- 2. the effect on early childhood development and preschool through post secondary education development;
- 3. the effect on employment and workforce development;
- 4. the effect on taxes and tax credits;
- 5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirement or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to the same level of service.

Public Comments

Interested persons may submit written comments on this proposed Rule no later than October 20, 2015, at 5 p.m. to the attention of Bob Wertz, Law Enforcement Training Manager, Louisiana Commission on Law Enforcement and Administration of Criminal Justice, P.O. Box 3133, Baton Rouge, LA 70821. He is responsible for responding to inquiries regarding this proposed Rule.

Lamarr Davis
Chairman

grant funding allotted annually to the Louisiana Commission on Law Enforcement (LCLE) through the Office for Victims of Crime (OVC) via the Victims of Crime Act (VOCA) is contingent upon the dollar amount of state funds the agency expends for crime victims in the preceding year. For every dollar spent in a particular fiscal year on reparations for crime victims, the OVC will appropriate sixty cents of VOCA funding in the next fiscal year. Therefore, increased state expenditures in FY 16 as a result of the proposed rule will generate additional federal funding for the agency in FY 17.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Implementation of the proposed rule will allow victims of sexual assault and healthcare providers to directly access healthcare benefits related to treatment for personal injury, and the ancillary medical costs of a forensic medical examination up to a maximum reimbursement of \$1,000 per case.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no effect on competition or employment in the public or private sector as a result of the proposed rule change.

Joseph Watson
Executive Director
1509#048

Evan Brasseaux
Staff Director
Legislative Fiscal Office

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Compensation to Victims

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule may result in an indeterminable net increase in expenditures from the statutorily dedicated Crime Victims Reparation (CVR) Fund, which is funded by fees associated with criminal court cases. Pursuant to Act 229 of 2015, claim benefits have been expanded to victims of sexually-oriented criminal offenses and health care organizations that treat victims. LCLE has obtained additional resources for funding health care benefits for victims of sexually-oriented offenses through Act 186 of 2015, which mandates that unclaimed gaming winnings at casinos and race tracks must be remitted to the State Treasury for placement in the CVR Fund at the end of each calendar year quarter. Resources derived from unclaimed gaming winnings will not be available until October 2015. LCLE anticipates using resources obtained via court fees, unclaimed gaming winnings, and federal grant awards to fund health care benefits for victims of sexually-oriented offenses at the program's outset. LCLE will evaluate the level of funding obtained through unclaimed gaming winnings, then will decide whether to continue using resources received via court fees as the program progresses, or to fund it using only unclaimed gaming winnings and federal grant awards.

Act 229 also establishes a \$1,000 maximum reimbursement per case for all healthcare organizations that perform forensic medical exams for the purpose of collecting evidence in the event the victim decides to report their case to law enforcement. For reference, Louisiana had 1,619 reported cases of rape in 2013 according to the Federal Bureau of Investigation's Uniform Crime Reporting (UCR) database. Due to the new laws expanding claim benefits to victims who do not report their crimes to law enforcement, as well as the CVR Fund issuing more claim awards than in previous years, net expenditures may increase by an indeterminable amount.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of the proposed rule may increase federal grant awards beginning in FY 17. The dollar amount of federal

NOTICE OF INTENT

Department of Health and Hospitals
Board of Examiners of Nursing Facility Administrators

Fees and Assessments (LAC 46:XLIX.1201)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:2501 et seq., that the Louisiana Board of Examiners of Nursing Facility Administrators proposes to amend LAC 46:XLIX.1201. The proposed Rule change increases the annual registration fee for licensed nursing facility administrators to provide sufficient revenues for increases in the operating costs of the Board of Examiners.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part XLIX. Nursing Facility Administrators
Chapter 12. Fees and Assessments
§1201. Fee Schedule

A. The board hereby establishes the following fees and costs to be imposed for the purpose of implementing and enforcing the provisions of this Part.

Administrator address labels/page	\$8
Annual Conditional Registration Fee	\$210
Annual Registration Fee	\$495
Application Packet	\$100
Certification of document as true copy	\$10
CNA/DSW Card	\$13
Continuing Education Provider (annually)	\$600
Delinquent fee	\$250
Directory of Administrators	\$15
Failure to maintain current information	\$80
Handling and mailing per page	\$2
Initial Registration Fee	\$395
Minimum Licensure Standards Book	\$15
NFA Application Fee	\$600

NFA Replacement Card (with photo)	\$17
NSF Fee	\$50
Photocopies of document/page	\$0.50
Reciprocity Fee (to another state)	\$50
Reciprocity Fee (to Louisiana)	\$125
Replace License Card	\$12
Replace License (original)	\$50
Replace Registration Certificate or 2nd copy	\$25
Request for CEU Approval (applicant)	\$50
Request for CEU Approval (vendor)	\$75
Seminars (per hour of instruction)	\$50
State Exam Fee	\$120
State Exam Retake Fee	\$150

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Nursing Facility Administrators, LR 37:596 (February 2011), amended LR 39:1047 (April 2013), LR 41:96 (January 2015), LR 41:

Family Impact Statement

The proposed amendments to LAC 46:XLIX.1201 should not have any impact on the family as defined by R.S. 49:972. There should not be any effect on: the stability of the family, the authority and rights of parents regarding the education and supervision of their children, the functioning of the family, family earnings and family budget, the behavior and personal responsibility of children, and/or the ability of the family or local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed amendments to LAC 46:XLIX.1201 should not have any known or foreseeable impact as described in R.S. 49:973.

Provider Impact Statement

The proposed amendments to LAC 46:XLIX.1201 should not have any known or foreseeable impact as defined by HCR 170 of 2014 Regular Legislative Session.

Public Comments

Interested persons may submit written comments until 4 p.m. on October 10, 2015 to Mark A. Hebert, Board of Examiners of Nursing Facility Administrators, 5647 Superior Drive, Baton Rouge, LA 70816.

Mark A. Hebert
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Fees and Assessments

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than the rule publication costs, the total of which are estimated to be \$300 during the current fiscal year, it is not anticipated that the proposed rule amendments will result in any costs or savings to the Board of Examiners, state or local governmental unit. The proposed rule change increases the annual registration fee for Licensed Nursing Facility Administrators and Administrators in Training in order to provide sufficient revenues for increases in the operating costs of the Board of Examiners.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The Board of Examiners will realize an increase in fees and self-generated revenues of approximately \$42,000 annually.

There is no anticipated effect on the revenue collections of other state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be an increase of \$100 for the initial and annual registration fee, impacting individuals renewing licensure as, or becoming, a Licensed Nursing Facility Administrator or a Licensed Nursing Facility Administrator in Training.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Individuals employed as, or seeking to become, Licensed Nursing Facility Administrators or Licensed Nursing Facility Administrators in Training will realize a \$100 increase in the initial and annual registration fee.

Mark A. Hebert
Executive Director
1509#017

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Medical Examiners

Physician Practice; Complaints and Investigations;
Adjudication (LAC 46:XLV.Chapters 97 and 99)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et. seq., and pursuant to the authority vested in the Louisiana State Board of Medical Examiners (Board) by the Louisiana Medical Practice Act, R.S. 37:1261-1292, as amended by Act 441 of the 2015 Session of the Louisiana Legislature, the board intends to adopt LAC 46:XLV Chapter 97, which will govern the investigation of complaints against physicians. It also plans to amend various sections of its existing rules relative to adjudication of alleged violations, LAC 46:XLV.Chapter 99. The proposed rules and amendments are set forth below.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions Subpart 5. Rules of Procedure

Chapter 97. Complaints and Investigations

§9701. Scope of Chapter

A. The rules of this Chapter govern the board's processing of complaints and investigations relative to the laws governing the practice of medicine by physicians, other state and federal laws to which physicians are subject and the board's rules. These rules are intended to supplement, but not replace, any applicable provision of the Louisiana Administrative Practice Act, R.S. 49:950 et seq. regarding the disciplinary process and procedures. To the extent that any rule of this Chapter is in conflict therewith, the provisions of the Louisiana Administrative Procedure Act shall govern.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9703. Definitions

A. As used in this Chapter, the following terms shall have the meanings specified.

Board—the Louisiana State Board of Medical Examiners, as established in the Louisiana Medical Practice Act, R.S. 37:1261-1292.

Complaint—any information, claim or report of whatsoever kind or nature received or obtained by the board that alleges or may indicate a violation of the law by a licensee.

Jurisdictional—a matter within the board's authority under the law.

Law (or the law)—unless the context clearly indicates other, the Louisiana Medical Practice Act, R.S. 37:1261-1292, other applicable laws administered by the board and the board's rules, LAC 46:XLV.101 et seq.

Physician or Licensee —an individual who holds a current license or permit duly issued by the board to practice medicine in this state pursuant to R.S. 37:1261-1292.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9705. Complaint Origination

A. Complaints may be initiated by any person or based on information independently developed by the board.

B. The board provides a complaint form on its website, www.lsbme.la.gov, which is to be completed, dated and signed by persons making complaints to the board. Use of the form is preferred but not required.

C. The board shall not take action on an anonymous complaint except when supported by apparently reliable information or evidence provided with the complaint or obtainable from another source.

D. The identity of and communications from a complainant constitute part of a preliminary review or investigative record of the board and shall be maintained in confidence by the board. Confidentiality shall be waived only by written authorization of the complainant, when the complainant will be offered as a witness in a formal administering hearing before the board or as otherwise provided by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9707. Complaint Processing

A. The board's staff processes all complaints and conducts all investigations on behalf of the board.

B. Any staff member of the board, except the executive director, may act as the lead investigator on any complaint received by the board regarding a physician or any investigation regarding a physician initiated by the board on its own motion.

C. To obtain evidence of violations of the law or assist in a review or investigation the executive director or a designee authorized by the board is authorized to issue, as necessary or upon request of board staff, such subpoenas as may be required to obtain documents and other information, the appearance of witnesses or sworn testimony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9709. Preliminary Review

A. Upon receipt of a complaint a preliminary review may be conducted to determine if the complaint is jurisdictional and whether sufficient cause exists to warrant formal investigation.

B. During a review such action may be initiated and taken as deemed necessary or appropriate and additional information may be obtained to assist in the determination. As part of the preliminary review:

1. documents and information which may be needed to determine if the complaint is jurisdictional and whether sufficient cause exist to warrant formal investigation may be gathered and secured;

2. the complainant may be contacted; and

3. the licensee may be provided the opportunity to respond to the complaint or provide related information; provided, at the time of the first communication from the board to a licensee regarding a complaint the licensee shall be provided:

a. a brief summary of the complaint or alleged violation or a copy of the complaint if authorization has been provided;

b. notice that the licensee may, at his own expense, retain legal counsel of his choice to represent his interest; and

c. such other information as may be deemed appropriate.

C. Any information gathered during the preliminary review will be added to the information maintained on the complaint.

D. Preliminary review of a complaint shall be completed as promptly as possible within one-hundred and eighty days of receipt. However, this period may be increased by the board for satisfactory cause and shall not apply to information received from local, state or federal agencies or officials relative to on-going criminal, civil or administrative investigations or proceedings.

E. Nothing in this Chapter requires that a preliminary review be conducted if the complaint or information clearly indicates the need for formal investigation or emergent action.

F. At the conclusion of a preliminary review a determination shall be made as to whether the complaint is jurisdictional and there is sufficient cause for investigation. If the complaint:

1. is not jurisdictional or there is insufficient cause for investigation, a report and recommendation shall be submitted to the board to close the complaint without investigation. If approved by the board, the complainant and the licensee, if the licensee was notified of the preliminary review, shall be notified of the disposition. If not approved by the board, a formal investigation shall be commenced in accordance with §9711 of these rules. A complaint closed after preliminary review shall not be considered an investigation by the board and need not be reported as such by a licensee on subsequent renewal applications to the board.

2. is jurisdictional and there is sufficient cause for investigation, a report and recommendation shall be

submitted to the board to commence a formal investigation. The report shall include:

- a. a brief summary of the complaint or alleged violation;
- b. a statement of the possible violations of the law involved; and
- c. a summary of the licensee's biographical, licensure and disciplinary history on file with the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9711. Formal Investigation

A. If the board determines by a majority vote of the members present and voting at a board meeting that a complaint warrants investigation it shall instruct board staff to initiate a formal investigation. If the board determines that a complaint does not warrant investigation it shall be closed pursuant to §9709F.1. of this Chapter.

B. Written notice of the investigation including a brief summary of the facts constituting the alleged violation shall be provided to the licensee no later than five business days after the board's formal investigation is initiated by registered, return-receipt-requested mail, as well as by regular first class mail, or by personal delivery or other means, at the most current address for the licensee reflected in the official records of the board. Such notice shall also include the information set forth in §9709B.3.a.-c. of this Chapter.

C. Once a formal investigation is initiated by the board, an investigation shall be undertaken to determine whether or not there is sufficient information and evidence to indicate that a violation of the law has occurred.

D. Past complaints and investigations of a licensee may be utilized in a current investigation for the purpose of determining if there is a pattern of practice or continuing or recurring conduct that fails to satisfy the prevailing and usually accepted standards of medical practice in this state on the part of the licensee.

E. If the complaint giving rise to the formal investigation involves medical incompetency, as part of the investigation a request may be made, or the board may order in a manner prescribed by §365D of these rules, the licensee to undergo a competency evaluation at a third-party evaluation center approved by the board.

F. If the investigation does not provide sufficient information and evidence to indicate that a violation of the law has occurred, a report and recommendation shall be made to the board that the investigation be closed without further action. If the board approves the recommendation, the complainant and the licensee shall be provided written notification of the disposition. If the recommendation is not approved, such further investigation or other action shall be taken as may be necessary or appropriate.

G. If the investigation provides sufficient information and evidence to indicate that a violation of the law has occurred, an administrative complaint may be filed with the board, pursuant to Chapter 99 of these rules, provided one or more of the following conditions exist:

1. a draft administrative complaint, in the form and content specified in §9903B of these rules, has been mailed or provided to the licensee accompanied by a letter providing a reasonable opportunity for a conference to show compliance with all lawful requirements for the retention of the license without restriction, or to show that the complaint is unfounded as contemplated by R.S. 49:961(C); however, the licensee fails to respond to the complaint and letter, waives the opportunity, or the response does not satisfactorily demonstrate lawful compliance or that the complaint is unfounded;

2. informal disposition is attempted but fails to resolve all of the issues and the procedures specified in §9711G.1 of this Section have been provided with the same result described;

3. emergency action is required to pursuant to §9931.

H. Formal investigations shall be completed within thirty-six months after initiated by the board. However, this period may be increased by the board for satisfactory cause and no complaint shall be dismissed solely because a formal investigation was not completed within this period. This period shall also not apply to any investigation pending on July 1, 2015.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9713. Informal Settlements and Consent Orders

A. The board may, before, during, or following an investigation, or after filing an administrative complaint, dispose of any complaint through informal disposition.

B. Informal dispositions may take the form of any disposition recognized by R.S. 49:955D, or any other form of agreement which adequately addresses the complaint or matter under review or investigation; provided, however, that such dispositions are considered by the board only upon the recommendation of the board's lead investigator with respect to the investigation and all such dispositions require approval by a majority vote of the board members present and voting at a board meeting.

C. Informal dispositions may be either non-disciplinary or disciplinary:

1. Non-disciplinary dispositions consist of correspondence, an informal conference and a letter of concern. These dispositions shall not constitute disciplinary action, are not a public record of the board and are not reported and distributed in the same manner as final decisions of the board.

2. Disciplinary dispositions consist of consent orders, and other orders and agreements, and stipulations for voluntary surrender of a license. These dispositions shall constitute disciplinary action, shall be a public record of the board, and are reported and distributed in the same manner as final decisions of the board.

D. Any matter may be referred to the board for administrative hearing without first offering an informal disposition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

Chapter 99. Adjudication

§9907. Response to Complaint; Notice of Representation

A. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:507 (June 1990), amended LR 41:

§9915. Disposition of Prehearing Motions

A. - B. ...

C. The president of the board or presiding officer of the hearing panel, as the case may be, may delegate the task of ruling on prehearing motions to the board's independent legal counsel appointed pursuant to §9921D, who is independent of complaint counsel and who has not participated in the investigation or prosecution of the case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:508 (June 1990), amended, LR 41:

§9916. Discovery

A. After filing and notice of an administrative complaint has been served pursuant to §9905 of this Chapter:

1. the parties or their respective counsel shall, within the time frames established by the prehearing conference order, provide the other with a list of all witnesses and copies of all exhibits that may be offered as evidence at the adjudication hearing. Respondent shall also be provided a copy of any written or recorded statement he may have provided to the board and any exculpatory material the board may possess concerning the respondent;

2. subpoenas and subpoenas duces tecum may be requested pursuant to §9917 of these rules and discovery may be conducted in accordance with the Louisiana Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9919. Prehearing Conference

A. In any case of adjudication noticed and docketed for hearing a prehearing conference shall be held among the parties or their respective counsel, together with the board's independent counsel appointed pursuant to §9921.D hereof,

for the purpose of simplifying the issues for hearing and promoting stipulations as to facts and proposed evidentiary offerings which will not be disputed at hearing.

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

1. - 5. ...

6. dates for exchanging and supplementing lists of witnesses and copies of exhibits that may be offered at the hearing and discovery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:509 (June 1990), amended, LR 41:

§9920. Recusal

A. Any board member who, because of bias or interest, is unable to assure a fair hearing shall be recused from that particular proceeding. The reasons for the recusal shall made part of the record. Should the majority of the board members be recused for a particular proceeding, the governor shall be requested to appoint a sufficient number of pro tem members to obtain a quorum for the proceeding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and 37:1270(A)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§9921. Conduct of Hearing; Record; Order

A. - F. ...

G. The order of proceedings in an adjudication hearing is as follows but may be altered at the discretion of the presiding officer or by agreement of the parties:

1. complaint counsel makes an opening statement of what he intends to prove, and what action is sought from the board;

2. respondent or his counsel makes an opening statement, explaining why he believes that the charges against respondent are not legally founded;

3. complaint counsel presents the evidence against the respondent;

4. respondent or his counsel cross examines;

5. respondent or his counsel presents evidence;

6. complaint counsel cross examines;

7. complaint counsel rebuts the respondent's evidence; and

8. each party makes closing statements. The complaint counsel makes the initial closing statement and the final statement.

H. The board may impose reasonable time limits on the parties provided that such will not unduly prejudice the rights of the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:509 (June 1990), amended, LR 41:

§9923. Evidence; Burden of Proof

A. - E. ...

F. Burden of Proof. Any final decision of the board shall be supported by a preponderance of the evidence presented during the administrative hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:509 (June 1990), amended, LR 41:

§9925. Informal Disposition

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:510 (June 1990), repealed, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of the proposed rules and amendments on the family has been considered. It is not anticipated that the proposed rules and amendments will have any impact on family, formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed rules and amendments on those that may be living at or below one hundred percent of the federal poverty line has been considered. It is not anticipated that the proposed rules and amendments will have any impact on child, individual or family poverty in relation to individual or community asset development, as described in R.S. 49:973.

Provider Impact Statement

In compliance with HCR 170 of the 2014 Regular Session of the Louisiana Legislature, the impact of the proposed rules and amendments on organizations that provide services for individuals with development disabilities has been considered. It is not anticipated that the proposed rules and amendments will have any impact on the staffing, costs or overall ability of such organizations to provide the same level of services, as described in HCR 170.

Public Comments

Interested persons may submit written data, views, arguments, information or comments on the proposed rules and amendments to Rita Arceneaux, Confidential Executive Assistant, Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, LA, 70130, (504) 568-6820, Ex. 242. She is responsible for responding to inquiries. Written comments will be accepted until 4 p.m., October 21, 2015. If a public hearing is requested to provide data, views, arguments, information or comments orally in accordance with the Louisiana Administrative Procedure Act, the hearing will be held on October 26, 2015, at 2:30 p.m. at the office of the Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, LA 70130. Any person wishing to attend should call to confirm that a hearing is being held.

Public Hearing

A request pursuant to R.S. 49:953(A)(2) for a public hearing must be made in writing and received by the Board within 20 days of the date of this notice.

Cecilia Mouton, M.D.
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Physician Practice; Complaints and Investigations; Adjudication

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

In conformity with Act 441 of the 2015 Session of the Louisiana Legislature, which amended the Louisiana Medical Practice Act by, among other items, enacting R.S. 37:1285.2, the Board of Medical Examiners proposes to adopt rules governing investigations and complaints (LAC 46:XLV Chapter 97), amend certain sections of its existing rules on adjudication (LAC 46:XLV Chapter 99) and make other changes consistent with the new law. All substantive changes with a fiscal impact are explained below.

The proposed rule will result in an estimated cost of \$422,429 in FY 16 and recurring costs of approximately \$340,000 beginning in FY 17. Estimated costs are attributable to: the need to hire a physician consultant separate from the physician executive director to conduct investigations (\$246,901 – base salary \$175,000 per year + \$64,750 retirement for state employees + \$4,613 group insurance per year + \$2,538 Medicare contribution = \$246,901 salary package) and a compliance investigator to monitor investigations, provide notice and insure compliance with other procedural requirements (\$74,240 – base salary \$50,000 per year + \$18,500 retirement for state employees + \$5,015 group insurance per year + \$725 Medicare contribution = \$74,240 salary package). The Board will also incur one-time costs to acquire a new software system to properly track and monitor investigations and complaints (\$100,000). Publication costs associated with notice (\$681) and promulgation (\$607) of the proposed rules and amendments are estimated at a combined total of \$1,288 in FY 16, for a total fiscal impact in FY 16 of \$422,429 (\$246,901 + \$74,240 + \$100,000 + \$1,288 = \$422,429). Recurring costs in FY 17 are estimated at \$339,601 (physician consultant \$256,592 + compliance investigator \$77,009 + \$6,000 software maintenance) and in FY 18 will be \$352,561 (physician consultant \$266,672 + compliance investigator \$79,889 + \$6,000 software maintenance). Out year estimates assume a 4% annual increase in personal services. Other than the initial and rule publication costs during the year FY 16, and recurring costs in following years, it is not anticipated that the proposed rules and amendments will have further impact on the Board or any other state or local governmental unit, inclusive of adjustments in workload and paperwork requirements.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no anticipated effect on the revenue collections of the Board of Medical Examiners or any state or local governmental unit.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

It is not anticipated that the proposed rules and amendments will have a material effect on costs, paperwork or workload of physicians, nor on receipts and/or income of licensees or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is not anticipated that the proposed rules and rule amendments will have any impact on competition or employment in either the public or private sector.

Cecilia Mouton, M.D.
Executive Director
1509#052

Evan Basseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Medical Examiners

Physician Practice; Marijuana for Therapeutic Use by
Patients Suffering from a Qualifying Medical Condition
(LAC 46:XLV.Chapter 77)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et. seq., and pursuant to the authority vested in the Louisiana State Board of Medical Examiners (board) by the Louisiana Medical Practice Act, R.S. 37:1261-1292, the board intends to adopt rules governing physicians who utilize therapeutic marijuana in the treatment of their patients who are suffering from a qualifying medical condition, LAC 46:XLV.Chapter 77. These rules are proposed for adoption in order to comply with the legislative mandate contained in Act 261 of the 2015 Session of the Louisiana Legislature, amending R.S. 40:1046, directing the board to promulgate such rules by January 1, 2016. The proposed rules are set forth below.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions

Subpart 3. Practice

Chapter 77. Marijuana for Therapeutic Use by Patients Suffering from a Qualifying Medical Condition

Subchapter A. General Provisions

§7701. Preamble, Warning, Suggested Consultation, and Rational for Terminology

A. Preamble, State Law. Pursuant to Act 261, R.S. 40:1046, of the 2015 Session of the Louisiana Legislature, the Louisiana State Board of Medical Examiners was directed to:

1. promulgate rules and regulations authorizing physicians licensed to practice in this state to prescribe marijuana for therapeutic use by patients clinically diagnosed as suffering from glaucoma, symptoms resulting from the administration of chemotherapy cancer treatment, and spastic quadriplegia; and

2. submit to the Senate and House Committees on Health and Welfare on an annual basis not less than 60 days prior to the beginning of the Regular Session of the Legislature a report as to any additional diseases or conditions that should be added to the list of eligible diseases and conditions for prescription.

B. Warning—Federal Law. Irrespective of Louisiana law, which as an agency of this state the board is obliged to adhere, marijuana is classified as a schedule I controlled substance under federal law and regulation and has not been approved by the United States Food and Drug Administration (USFDA) for the treatment of any medical condition. Prescribing marijuana is illegal under federal law and physicians who do so may be subject to criminal, civil and administrative consequences that include, among others, federal criminal prosecution, civil fines, forfeitures, penalties, revocation of controlled dangerous substance registration issued by the United States Drug Enforcement Administration, exclusion from Medicare and other federal

payer programs, etc. Patients who possess marijuana, on the written request or recommendation of a physician or otherwise, may also be exposed to federal criminal prosecution, civil fines, forfeitures and penalties. Neither Louisiana nor the board's rules preempt federal law, which may also impact the methods of payment to physicians for visits when therapeutic marijuana is requested or recommended and inhibit the deposit of proceeds from such visits into banks and other federally insured institutions.

C. Consultation. For the foregoing reasons, physicians may wish to consult with their own legal counsel, as well as any health care facility, private or governmental payor with which the physician is affiliated, medical malpractice insurers and financial institutions before suggesting marijuana for the treatment of a qualifying medical condition in their patients.

D. Rational for Terminology. Under Louisiana law, R.S. 40:961(32), the word *prescribe* means “[T]o issue a written request or order for a controlled dangerous substance by a person licensed under this Part for a legitimate medical purpose. The act of prescribing must be in good faith and in the usual course of the licensee's professional practice.” Because some other states that have authorized physicians to issue a *written request* or *recommendation* or *order* for marijuana for qualifying medical conditions may be viewed as not directly transcending the federal prohibition against dispensing (and prescribing) marijuana and considering the definition of the word *prescribe* which was used in Act 261, these rules shall utilize the term *written request* or *recommendation* when describing a physician's direction to a licensed therapeutic marijuana pharmacy to provide marijuana for therapeutic use by patients who suffer from a qualifying medical condition. We do so with the caution that this attempt to minimize what may be viewed as a conflict between Act 261's direction to the board with controlling federal law by the use of this term in these rules, and in rules and laws of other states that have utilized the same or similar terms for this purpose, nevertheless remain subject to criminal, civil and administrative prosecution by federal authorities in the exercise of their discretionary authority to enforce federal law and regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and R.S. 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

§7703. Scope of Chapter

A. This Chapter is being adopted in order to comply with the obligations imposed upon the board by Act 261, R.S. 40:1046, of the 2015 Session of the Louisiana Legislature and govern a physician's written request or recommendation for the therapeutic use of marijuana for a patient suffering from a qualifying medical condition with whom the physician has established a bona-fide physician-patient relationship.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292 and R.S. 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

§7705. Definitions

A. As used in this Chapter, the following terms and phrases shall have the meanings specified.

Board—The Louisiana State Board of Medical Examiners, as established in R.S. 37:1261-1292.

Bona-Fide Physician-Patient Relationship—a relationship in which a physician:

- a. has conducted at least one in-person examination at a physical practice location in this state;
- b. maintains a medical record in accordance with professional standards; and
- c. is responsible for the ongoing assessment, care and treatment of a patient's qualifying medical condition, or a symptom of the patient's qualifying medical condition.

Controlled Substance—any medication or other substance which is designated as a controlled substance and regulated as such under Louisiana or federal law or regulations.

Licensed Therapeutic Marijuana Pharmacy—a pharmacy located in this state that is licensed by and in good standing with the Louisiana Board of Pharmacy to provide therapeutic marijuana to a patient on the written request or recommendation of the patient's physician.

Medical Practice Act or the Act— R.S. 37:1261-92, as may from time-to-time be amended.

Marijuana—tetrahydrocannabinols, or a chemical derivative of tetrahydrocannabinols in any form, except for inhalation, raw or crude marijuana, as permitted by the rules and regulations of the Louisiana Board of Pharmacy.

Patient—an individual who:

- a. is a resident of this state;
- b. has a current clinical diagnoses of a qualifying medical condition; and
- c. with whom the physician has a *bona-fide* physician-patient relationship.

Physical Practice Location in this State—a clinic or office physically located in this state where the physician spends the majority of his or her time practicing medicine.

Physician—an individual lawfully entitled to practice of medicine in this state, as evidenced by a current license duly issued by the board.

Prescription Monitoring Program or PMP—the prescription monitoring program established by R.S. 40:1001 et seq., as may from time to time be amended.

Qualifying Medical Condition—glaucoma, symptoms resulting from the administration of chemotherapy cancer treatment, spastic quadriplegia, and/or such other diseases or conditions that may subsequently be identified as a qualifying medical condition by amendment of R.S. 40:1046 or other state law.

Registrant—a physician who is registered with the board to issue a written request or recommendation for the use of marijuana for therapeutic purposes.

Written Request or Recommendation—written direction transmitted in a form and manner specified in §7721 of this Chapter, to a licensed therapeutic marijuana pharmacy. The issuance of a written request or recommendation must be in good faith and in the usual course of the physician's professional practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

Subchapter B. Prohibitions and Exceptions

§7707. Prohibitions

- A. No physician shall:
 1. issue a written request or recommendation for therapeutic marijuana unless he or she is registered with the

board and complies with Louisiana law and the rules of this Chapter;

2. issue a written request or recommendation for therapeutic marijuana to more than 100 patients; provided, however, the board may grant an exception to this requirement pursuant to §7709B of this Subchapter;

3. not delegate to any other healthcare professional or other person the authority to diagnose the patient as having a qualifying medical condition;

4. examine a patient at any location where marijuana is provided; or

5. have an ownership or investment interest established through debt, equity, or other means, whether held directly or indirectly by a physician or a member of a physician's immediate family, nor any contract or other arrangement to provide goods or services, in or with a licensed therapeutic marijuana pharmacy or a producer licensed by the Louisiana Department of Agriculture and Forestry to produce marijuana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7709. Exceptions

A. The rules of this Chapter shall not apply to a physician's prescription of cannabinoid derived pharmaceuticals that are approved by the USFDA for administration to patients.

B. Upon written application the board may, in its discretion, authorize a physician to exceed the patient limit set forth in §7707.A.2 of this Subchapter. The application shall contain a statement by the physician of the specific manner in which the physician proposes to deviate from such limit, together with a statement of the medical facts and circumstances deemed by the physician to justify such departure, and such other information and documentation as the board may request. The board's action on any such application shall be stated in writing and shall specify the manner and extent to which the physician shall be authorized to exceed the patient limit set forth in §7707.A.2 and the period of time during which such authorized exception shall be effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

Subchapter C. Registration

§7711. Registration, Physician Eligibility

A. To be eligible for registration under this Chapter a physician shall, as of the date of the application:

1. hold a current, unrestricted license to practice medicine issued by the board;

2. hold current schedule I authority or such other authority as may be designated for therapeutic marijuana by the Louisiana Board of Pharmacy;

3. practice at a physical practice location in this state; and

4. complete an on-line educational activity available at no cost on the board's web page.

B. A physician shall be deemed ineligible for registration who has:

1. has been convicted, whether upon verdict, judgment, or plea of guilty or nolo contendere, of a felony or

any crime an element of which is the manufacture, production, possession, use, distribution, sale or exchange of any controlled substance or who has entered into a diversion program, a deferred prosecution or other agreement in lieu of the institution of criminal charges or prosecution for such crime;

2. has within the 10 years preceding application for registration, abused or excessively used any medication, alcohol, or other substance which can produce physiological or psychological dependence or tolerance or which acts as a central nervous system stimulant or depressant; or

3. is the subject of a pending formal investigation or administrative proceeding before the board.

C. The board may deny registration to an otherwise eligible physician for any of the causes enumerated by R.S. 37:1285 or any other violation of the provisions of the Act.

D. The burden of satisfying the board as to the qualifications and eligibility of the physician-applicant for registration shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7713. Application

A. Application for registration shall be made in a format approved by the board and shall include:

1. the applicant's full name, contact information, and such other information and documentation as the board may require;

2. criminal history record information; and

3. an application fee of \$75.

B. The board may refuse any application that is not complete and may require a more detailed or complete response to any request for information in the application.

C. Applications and instructions may be obtained from the board's webpage, www.lsbme.la.gov, or by contacting the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, 1281, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7715. Registration Issuance, Expiration, Renewal

A. If the qualifications, requirements, and procedures set forth in this Chapter are met to the satisfaction of the board, registration shall be issued to the applicant.

B. Registration shall expire and become null, void, and to no effect the following year after issuance on the last day of the month in which the registrant was born.

C. Registration shall be renewed annually on or before its date of expiration by submitting to the board a renewal application and a renewal fee of \$50.

D. Registration which has expired as a result of nonrenewal may be reinstated upon the applicant's satisfaction of the qualifications, requirements and procedures prescribed for original application for registration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, 1281, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

Subchapter D. Marijuana for Therapeutic Purposes, Limitations, Access to Records

§7717. Use of Marijuana for Therapeutic Purposes, Limitations

A. Required Prior Conditions. Nothing in this Chapter requires that a physician issue a written request or recommendation for marijuana. However, if a physician determines it medically appropriate to do so to treat or alleviate symptoms of a patient's qualifying medical condition the physician shall comply with the following rules.

1. Medical Diagnosis. A medical diagnosis of a qualifying medical condition shall be clinically established and clearly documented in the patient's medical record. The diagnosis shall be supported by an assessment of the patient, a review of the patient's medical history, prescription history, an assessment of current coexisting illnesses, diseases, or conditions, and an in-person physical examination.

2. Prescription Monitoring Program. The physician shall review the patient's information in the Prescription Monitoring Program database prior to issuing any written request or recommendation for marijuana.

3. Independent Medical Judgment. A physician's decision to utilize marijuana in the treatment of a patient must be based on the physician's independent medical judgment that the drug is likely to provide a therapeutic benefit in the treatment of the patient's qualifying medical condition and that such use would likely outweigh the health risks of other options that could be used for the patient.

4. Treatment Plan. An individualized treatment plan shall be formulated and documented in the patient's medical record which includes medical justification for the use of marijuana. The plan shall include documentation that other medically reasonable alternative treatments for the patient's qualifying medical condition have been considered or attempted without adequate or reasonable success.

5. Informed Consent. A physician shall explain the potential risks and benefits of the therapeutic use of marijuana and any alternative treatments to the patient. Among other items, informed consent should caution against driving, operating machinery or performing any task that requires the patient to be alert or react when under the influence of the drug and the need for secure storage to reduce the risk of exposure to children or diversion by others. A physician shall also advise patients that therapeutic marijuana has not been approved by the USFDA for the treatment of any medical condition, that possession may be viewed as illegal under federal law and subject to federal (and workplace) enforcement action. Discussion of the risks and benefits should be clearly noted in the patient's record. If the patient is a minor a custodial parent or legal guardian shall be fully informed of the risks and benefits and consent to such use.

6. Continued Use of Marijuana. The physician shall monitor the patient's progress closely, re-examine the patient at intervals not to exceed 90 days to assess the benefits of treatment, assure the therapeutic use of marijuana remains indicated, and evaluate the patient's progress toward treatment objectives. Exceptions to this interval shall be adequately documented in the patient's record. During each visit, attention shall be given to the possibility that marijuana use is not masking an acute or treatable progressive condition or that such use will lead to a worsening of the

patient's condition. Indications of substance abuse or diversion should also be evaluated.

7. Medical Records. A physician shall document and maintain in the patient's medical record, accurate and complete records of the medical diagnoses of a qualifying medical condition, PMP inquiries, consultations, treatment plans, informed consents, periodic assessments, and the results of all other attempts which the physician has employed alternative to marijuana. A physician shall also document the date, type, quantity, dosage, route, and frequency of each written request or recommendation for marijuana which the physician has made for the patient. A copy of a written request or recommendation shall suffice for this purpose.

B. Termination of Use. A physician shall refuse to initiate or re-initiate or shall terminate the use of marijuana with respect to a patient on any date that the physician determines, becomes aware, knows, or should know that:

1. the patient is not a qualifying candidate for the use of marijuana under the conditions and limitations prescribed by this Section;

2. the patient has failed to demonstrate clinical benefit from the use of marijuana; or

3. the patient has engaged in diversion, excessive use, misuse, or abuse of marijuana or has otherwise consumed or disposed of the drug other than in compliance with the directions and indications for use given by the physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

§7719. Board Access to Records

A. The records required by this Subchapter shall be available for examination, inspection and copying by the board or its designated employee or agent at any reasonable time, but without the necessity of prior notice by the board. The failure or refusal of a registrant to make such records available pursuant to this Section shall constitute a violation of these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

§7721. Form of Written Request or Recommendation

A. Required Contents. A written request or recommendation for therapeutic marijuana shall include:

1. the physician's name, address, telephone number, e-mail address, registration number issued under this Chapter, and Louisiana schedule I or other license number for therapeutic marijuana issued by the Louisiana Board of Pharmacy;

2. the name, address and date of birth of the patient;

3. the date, name and address of the licensed therapeutic marijuana pharmacy to whom the written request or recommendation is being transmitted;

4. the form, amount, dosage and instructions for use of therapeutic marijuana in an amount which is not greater than that necessary to constitute an adequate supply for a period of one month, including amounts for topical treatment; and

5. confirmation that the written request or recommendation for therapeutic marijuana is being submitted for the physician's patient as defined by and in and conformity with the rules of this Chapter.

B. Approved Form. Direction provided to a pharmacist substantially in the form of the written request or recommendation form prescribed in the Appendix to these rules (§7729) shall be presumptively deemed to satisfy the requirements of this Section.

C. Manner of Transmission. A written request or recommendation for therapeutic marijuana shall be transmitted by the physician or physician's designee to a licensed therapeutic marijuana pharmacy in a manner that provides for medical/health information privacy and security and is in compliance with rules promulgated by the Louisiana Board of Pharmacy. The pharmacy shall be selected by the patient from a list of licensed therapeutic marijuana pharmacies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

Subchapter E. Sanctions, Effective Date, Severability

§7723. Sanctions Against Medical License or Registration

A. For noncompliance with any of the provisions of this Chapter the board may suspend, revoke, refusal to issue or impose probationary or other terms, conditions and restrictions on any license or permit to practice medicine in the state of Louisiana, or any registration issued under this Chapter, held or applied for by a physician culpable of such violation under R.S. 37:1285(A)(6), and R.S. 1285(A)(30), respectively.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7725. Effective Date

A. The effective date of the rules of this Chapter shall be November 20, 2016, or such earlier date on which final rules have been published in the *Louisiana Register* by the Louisiana Board of Pharmacy and the Louisiana Department of Agriculture and Forestry, in accordance with R.S. 40:1046.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7727. Severability

A. If any rule, provision, or item of this Chapter or the application thereof is held invalid as in excess of or inconsistent with statutory or constitutional authority, such invalidity shall not affect other rules, provisions, items, or applications, and to this end the rules and provisions of this Chapter are hereby declared to be severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 1270, and 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 41:

§7729. Appendix—Form of Written Request or Recommendation for Therapeutic Marijuana

—THIS IS NOT A PRESCRIPTION—
**PHYSICIAN WRITTEN REQUEST
 OR RECOMMENDATION FORM**

Section A. Patient’s Physician Information (Required)

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)
4a. Full Professional Address (street, city (in LA), zip code) 4b. e-mail address 4c. fax number			
5. City	6. State	7. Zip Code	8. Telephone Number
9a. LSBME Registration No. for Therapeutic Marijuana No. _____		9b. Schedule I No. (Board of Pharmacy) for Therapeutic Marijuana No. _____	

Section B. Patient Information (Required)

10. Legal First Name	11. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., III, etc.)
13. Date of Birth	14. Full Address of Patient [street, city (in LA), zip code]		

Section C. Patient’s Qualifying Medical Condition(s) (Required)

This patient has been diagnosed with the following qualifying medical condition: (A minimum of one condition must be checked)	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Symptoms from chemotherapy cancer treatment	
<input type="checkbox"/> Spastic quadriplegia	

Section D. Form, Amount, Dose, and Instructions for Use of Therapeutic Marijuana (Required)

Section E. Certification, Signature and Date (Required)

By signing below, I attest that the information entered on this written request or recommendation is true and accurate. I further attest that the above-named individual is my patient, who suffers from a qualifying medical condition and that this written request or recommendation is submitted by and in conformity with Louisiana Law, R.S. 40:1046, and administrative rules promulgated by the Louisiana State Board of Medical Examiners, LAC 46:XLV.Chapter 77.
Signature of Physician: X _____
Date: _____

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, and R.S. 40:1046.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of the proposed rules on the family has been considered. It is not anticipated that the proposed rules will have any impact on family, formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed rules on those that may be living at or below 100 percent of the federal poverty line has been considered. It is not anticipated that the proposed rules will have any impact on child, individual or family poverty in relation to individual or community asset development, as described in R.S. 49:973.

Provider Impact Statement

In compliance with HCR 170 of the 2014 Regular Session of the Louisiana Legislature, the impact of the proposed

rules on organizations that provide services for individuals with development disabilities has been considered. It is not anticipated that the proposed rules will have any impact on the staffing, costs or overall ability of such organizations to provide the same level of services, as described in HCR 170.

Public Comments

Interested persons may submit written data, views, arguments, information or comments on the proposed amendment to Rita Arceneaux, Confidential Executive Assistant, Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, LA 70130, (504) 568-6820, Ex. 242. She is responsible for responding to inquiries. Written comments will be accepted until 4 p.m., October 21, 2015.

Public Hearing

A request pursuant to R.S. 49:953(A)(2) for a public hearing must be made in writing and received by the board within 20 days of the date of this notice. If a public hearing is requested to provide data, views, arguments, information or comments orally in accordance with the Louisiana Administrative Procedure Act, the hearing will be held on October 26, 2015, at 3:30 p.m. at the office of the Louisiana State Board of Medical Examiners, 630 Camp Street, New

Orleans, LA 70130. Any person wishing to attend should call to confirm that a hearing is being held.

Cecilia Mouton, M.D.
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Physician Practice; Marijuana for Therapeutic Use by Patients Suffering from a Qualifying Medical Condition**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

In conformity with Act 261 of the 2015 session of the Louisiana legislature, which amended R.S. 40:1046, the Board of Medical Examiners proposes to adopt rules governing physicians who issue written requests or recommendations for therapeutic marijuana for their patients who suffer from a qualifying medical condition (LAC 46:XLV Chapter 77).

Other than one-time costs for notice (\$1,233) and rule promulgation (\$1,115) estimated at a total of \$2,348 in FY 16, it is not anticipated that the proposed rules will result in any additional costs or savings to the Board or other state or local governmental units. The Board anticipates devoting some administrative resources to processing initial registrations for physicians who recommend therapeutic marijuana for their patients. The number of physician applicants whom may seek registration is unknown but believed to be relatively small in number and renewal applications will be included in and processed with existing systems for annual renewals of medical licensure. The Board anticipates it can absorb the projected modest increase in administrative workload with existing personnel and resources.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation of the proposed rules will generate fees of \$75/\$50 for registration issuance/renewal. The Board anticipates that no registrations will be issued or renewed in fiscal year FY 16,. The Board estimates 25 new registration applicants are projected for each of the following two fiscal years. Estimated additional agency revenue from registration issuance/renewal will total: \$1,875 for FY 2017 (new registrations - 25 x \$75 = \$1,875) and \$3,125 in FY 18 (new registrations - 25 x \$75 = \$1,875; renewals - 25 x \$50 = \$1,250; \$1,875 new registrations + \$1,250 renewals = \$3,125). The Board is not in a position to estimate the number of new applicants in forthcoming years. Additional annual revenues will be utilized to off-set the Board's general operating expenses.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Because there is no information or data available either as to the number of physicians who may register to issue a written request or recommendation for therapeutic marijuana for their patients, or the number of patients for whom it may be utilized, it is not possible to estimate the impact of the proposed rules on receipts and/or income of licensees or non-governmental groups.

The proposed rules will affect any physician practicing medicine in this state who wishes to issue a written request or recommendation for therapeutic marijuana for his or her patients who suffer from a qualifying medical condition. Aside from an application form supplied by the Board for initial issuance or renewal of registration, a physician must satisfy the application requirements and pay the applicable fee. The proposed rules include compliance with specified conditions

both prior to the issuance of a written request or recommendation for therapeutic marijuana and while such therapy is being utilized.

As set forth in the proposed rules (7701), physicians who request or recommend therapeutic marijuana for a patient who suffers from a qualifying medical condition, as well as a patient who possesses it, may be exposed to federal enforcement action.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is not anticipated that the proposed rules will have any impact on competition or employment in either the public or private sector.

Cecilia Mouton, M.D.
Executive Director
1509#053

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Disproportionate Share Hospital Payments Inpatient Psychiatric Services Reimbursement Rate Reduction (LAC 50:V.959 and 2709)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:V.959 and §2709 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services amended the provisions governing the reimbursement methodology for inpatient hospital services in order to provide supplemental Medicaid payments to non-rural, non-state acute care hospitals that enter into a cooperative endeavor agreement with the department to provide inpatient psychiatric services (*Louisiana Register*, Volume 39, Number 2). The department amended the provisions governing disproportionate share hospital (DSH) payments to non-state distinct part psychiatric units that enter into a cooperative endeavor agreement with the department's Office of Behavioral Health (*Louisiana Register*, Volume 39, Number 3).

As a result of a budgetary shortfall in state fiscal year 2016, the department promulgated an Emergency Rule which amended the provisions governing DSH payments to reduce the payments made to non-rural, non-state acute care hospitals for inpatient psychiatric services (*Louisiana Register*, Volume 41, Number 9). This proposed Rule is being promulgated to continue the provisions of the October 1, 2015 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§959. Inpatient Psychiatric Hospital Services

A. - L. ...

M. Effective for dates of service on or after October 1, 2015, the prospective per diem rate paid to non-rural, non-state acute care hospitals that enter into a CEA with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to uninsured patients, shall be reduced by 5 percent of the per diem rate on file as of September 30, 2015. The new per diem rate shall be \$552.05 per day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 39:94 (January 2013), LR 39:323 (February 2013), LR 41:

**Subpart 3. Disproportionate Share Hospital Payments
Chapter 27. Qualifying Hospitals
§2709. Distinct Part Psychiatric Units**

A. - C. ...

D. Effective for dates of service on or after October 1, 2015, the prospective per diem rate paid to non-rural, non-state acute care hospitals that enter into a CEA with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to uninsured patients, shall be reduced by 5 percent of the per diem rate on file as of September 30, 2015 for distinct part psychiatric unit services. The new per diem rate shall be \$552.05 per day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1627 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:505 (March 2013), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have an adverse impact on family functioning, stability or autonomy as described in R.S. 49:972 in the event that provider participation in the Medicaid Program is diminished as a result of reduced reimbursement rates.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have an adverse impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 in the event that health care assistance is reduced as a result of diminished provider participation due to the reimbursement rate reductions.

Provider Impact Statement

In compliance with House Concurrent Resolution 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may increase the total direct and indirect cost to the provider to provide the same level of service due to the reduction of these payments. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if the reduction in payments adversely impacts the provider's financial standing.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Disproportionate Share Hospital
Payments—Inpatient Psychiatric Services
Reimbursement Rate Reduction**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic savings of \$115,975 for FY 15-16, \$160,139 for FY 16-17 and \$164,944 for FY 17-18. It is anticipated that \$648(\$324 SGF and \$324 FED) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by approximately \$190,802 for FY 15-16, \$262,058 for FY 16-17 and \$269,919 for FY 17-18. It is anticipated that \$324 will be expended in FY 15-16 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule continues the provisions of the October 1, 2015 emergency rule which amended the provisions governing disproportionate share hospital (DSH) payments to reduce DSH payments to qualifying hospitals for inpatient psychiatric services to avoid a budget deficit in FY 2015-16. It is anticipated that implementation of this proposed rule will reduce programmatic expenditures for DSH payments by approximately \$307,425 for FY 15-16, \$422,197 for FY 16-17 and \$434,863 for FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition. However, it is anticipated that the implementation of this proposed rule may have a negative effect on employment as it will reduce the payments made for inpatient psychiatric hospital services. The reduction in payments may adversely impact the financial standing of providers and could possibly cause a reduction in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1509#078

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

Facility Need Review
(LAC 48:I.Chapter 125)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 48:I.Chapter 125 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2116. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the facility need review (FNR) process to adopt provisions governing the inclusion of outpatient abortion facilities in the FNR Program (*Louisiana Register*, Volume 38, Number 8). The department promulgated an Emergency Rule which amended the provisions governing the FNR Program in order to revise the definition for *home and community-based service providers* to include monitored in-home caregiving (MIHC) services, and to revise the provisions governing the service area for adult day health care providers (*Louisiana Register*, Volume 40, Number 11). The department subsequently promulgated an Emergency Rule which amended the provisions of the November 20, 2014 Emergency Rule governing the Facility Need Review program in order to: 1) clarify the definition of *adult residential care* providers; 2) provide a process for supplementing an FNR application that has been denied prior to appeal; 3) provide time frames within which certain providers must become licensed after they have been approved through the FNR process; and 4) amend the provisions governing the FNR process for nursing facilities relative to the statutory moratorium (*Louisiana Register*, Volume 41, Number 9). This proposed Rule continues the provisions of the September 20, 2015 Emergency Rule.

**Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 5. Health Planning**

**Chapter 125. Facility Need Review
Subchapter A. General Provisions**

§12501. Definitions

A. ...

Adult Residential Care Provider (ARCP)—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group, which provides adult residential care services for compensation to two or more adults who are unrelated to the licensee or operator. Adult residential care includes, but is not limited to the following services: lodging, meals, medication administration, intermittent nursing services, and assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping and laundry. For the purposes of this FNR Rule, ARCP refers to an entity that is or will be licensed as an “ARCP level 4-adult residential care provider”.

Home and Community Based Service (HCBS) Providers—those agencies, institutions, societies, corporations, facilities, person or persons, or any other group intending to provide or providing respite care services, personal care attendant (PCA) services, supervised independent living (SIL) services, monitored in-home caregiving (MIHC) services, or any combination of services thereof, including respite providers, SIL providers, MIHC providers, and PCA providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:135 (January 2015), LR 41:

§12505. Application and Review Process

A. - B.3.b. ...

4. If FNR approval is denied, the applicant may choose to:

a. pursue an administrative appeal pursuant to Subchapter G, §12541; or

b. within 30 days of receipt of the notice of denial of FNR approval, and prior to filing an administrative appeal, request a supplemental review of additional documentation to be submitted by the applicant;

i. the time period to submit the supplemental materials shall be no later than 30 days from the date the request is approved by the department and notice received by the applicant. If timely received, the supplemental documentation will be reviewed in conjunction with the original FNR application. The applicant will receive the results of such review in writing from the department;

ii. in the case of a failure to submit the supplemental materials in a timely manner or, upon a denial

of the supplemental application, the applicant may file an administrative appeal of the department's decision with the Division of Administrative Law (DAL). This request shall be submitted within 30 days of the date of receipt of notice of said failure or denial;

iii. failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department and the decision to deny FNR approval is final;

c. the administrative appeal shall be conducted by the DAL in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), LR 35:2438 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 41:

Subchapter B. Determination of Bed, Unit, Facility or Agency Need

§12508. Pediatric Day Health Care Providers

A. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. PDHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. PDHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:136 (January 2015), amended LR 41:

§12511. Nursing Facilities

A. - J.4.a. ...

NOTE: Pursuant to R.S. 40:2116(D)(2), the Department of Health and Hospitals shall not approve any additional nursing facilities or additional beds in nursing facilities through facility need review. This prohibition shall apply to additional licensed beds as well as Medicaid certified beds. This prohibition shall not apply to the replacement of existing facilities, provided that there is no increase in existing nursing home beds at the replacement facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2615 (December 2008), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing, LR 37:3264 (November 2011), LR 41:

§12523. Home and Community-Based Service Providers

A. - E.3. ...

F. FNR-approved HCBS applicants shall become licensed no later than six months from the date of the FNR approval.

1. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant. Inappropriate zoning is not a basis for extension.

2. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the HCBS agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2438 (November 2009), amended LR 41:

§12525. Adult Day Health Care Providers

A. ...

B. For purposes of facility need review, the service area for a proposed ADHC provider shall be within a 30 mile radius of the proposed physical address where the provider will be licensed.

C. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. ADHC facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. ADHC facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the ADHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:323 (February 2010), amended LR 41:

§12526. Hospice Providers

A. - E.3. ...

F. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and/or licensure.

1. Outpatient hospice agencies shall be licensed within six months from the date of the FNR approval.

2. Inpatient hospice facilities which are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

3. Inpatient hospice facilities which are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

4. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant.

5. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the hospice agency or facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1593 (July 2012), amended LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Facility Need Review

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 15-16. It is anticipated that \$1,188 (SGF) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no effect on revenue collections.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule continues the provisions of the September 20, 2015 emergency rule which amended the provisions governing the Facility Need Review (FNR) program in order to: 1) provide a process for supplementing an FNR application that has been denied prior to appeal; 2) provide time frames within which home and community-based service providers must become licensed after they have been approved through the FNR process; and 3) amend the provisions governing the FNR process for nursing facilities relative the statutory moratorium. It is anticipated that the implementation of this proposed rule will have no economic cost or benefits to providers who must undergo the FNR process in FY 15-16, FY 16-17, and FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello
Health Standards Section Director
1509#079

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Federally Qualified Health Centers
Service Limits
(LAC 50:XI.10303)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XI.10303 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing federally qualified health centers (FQHCs) to provide Medicaid reimbursement for diabetes self-management training services (*Louisiana Register*, Volume

37, Number 9). The department now proposes to amend the provisions governing FQHC service limits in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XI. Clinic Services

Subpart 13. Federally-Qualified Health Centers

Chapter 103. Services

§10303. Service Limits

[Formerly §10503]

A. There shall be no limits placed on the number of federally qualified health center visits (encounters) payable by the Medicaid program for eligible recipients.

B. - B.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2280 (October 2010), LR 37:2629 (September 2011), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it will allow greater access to routine physician services at federally qualified health centers.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families for services rendered that exceed the current allowable visits per calendar year.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the direct or indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service since this proposed Rule may increase payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to

MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Federally Qualified Health Centers Service Limits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of \$321 for FY 15-16, \$217 for FY 16-17 and \$224 for FY 17-18. It is anticipated that \$432 (\$216 SGF and \$216 FED) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$389 for FY 15-16, \$356 for FY 16-17 and \$366 for FY 17-18. It is anticipated that \$216 will be expended in FY 15-16 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing federally qualified health center (FQHC) service limits in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older. It is anticipated that implementation of this proposed rule will increase programmatic expenditures in the Medicaid program for FQHC services by approximately \$278 for FY 15-16, \$573 for FY 16-17 and \$590 for FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition. However, it is anticipated that the implementation of this proposed rule may have a positive effect on employment as it will increase the payments made to providers. The increase in payments may improve the financial standing of FQHCs and could possibly cause an increase in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1509#080

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Home and Community-Based Services Providers
Licensing Standards
(LAC 48:I.Chapters 50 and 51)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 48:I.Chapter 50 and adopts Chapter 51 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2120.2. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the licensing standards for home and community-based services (HCBS) providers to revise the definitions and the staffing qualifications (*Louisiana Register*, Volume 40, Number 5).

The department promulgated an Emergency Rule which amended the provisions governing the licensing standards for HCBS providers to clarify these provisions and to include licensing provisions for monitored in-home caregiving services (*Louisiana Register*, Volume 40, Number 11). This proposed Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 50. Home and Community-Based Services Providers Licensing Standards

Subchapter A. General Provisions

§5001. Introduction

A. - B. ...

C. Providers of the following services shall be licensed under the HCBS license:

1. - 5. ...

6. supervised independent living (SIL), including the shared living conversion services in a waiver home;

7. supported employment; and

8. monitored in-home caregiving (MIHC).

D. The following entities shall be exempt from the licensure requirements for HCBS providers:

1. - 4. ...

5. any person who is employed as part of a Department of Health and Hospitals' authorized self-direction program; and

a. For purposes of these provisions, a self-direction program shall be defined as a service delivery option based upon the principle of self-determination. The program enables clients and/or their authorized representative(s) to become the employer of the people they choose to hire to provide supports to them.

6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

38:63 (January 2012), amended LR 38:1410 (June 2012), LR 41:1007 (May 2014), LR 41:

§5003. Definitions

* * *

Monitored In-Home Caregiving—services provided by a principal caregiver to a client who lives in a private unlicensed residence. The principal caregiver shall reside with the client, and shall be contracted by the licensed HCBS provider having a MIHC service module.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:64 (January 2012), amended LR 41:1007 (May 2014), LR 41:

§5005. Licensure Requirements

A. - B.8....

C. An HCBS provider shall provide only those home and community-based services or modules:

1. specified on its license; and

2. only to clients residing in the provider's designated service area, DHH Region, or at the provider's licensed location.

D. - J.1, Example. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:65 (January 2012), amended LR 41:

§5007. Initial Licensure Application Process

A. ...

B. The initial licensing application packet shall include:

1. - 9. ...

10. any other documentation or information required by the department for licensure including, but not limited to, a copy of the facility need review approval letter.

C. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended LR 41:

Subchapter D. Service Delivery

§5043. Contract Services

A. ...

B. When services are provided through contract, a written contract must be established. The contract shall include all of the following items:

1. - 4. ...

5. a statement that the person contracted shall meet the same qualifications and training requirements as the position being contracted;

B.5.a. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), LR 41:

Subchapter F. Provider Responsibilities

§5055. Core Staffing Requirements

A. - D.4....

E. Direct Care Staff

1. ...

2. The provider shall employ, either directly or through contract, direct care staff to ensure the provision of home and community-based services as required by the ISP.

E.3. - M.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended LR: 40:1001 (May 2014), LR 41:

Chapter 51. Home and Community-Based Services Providers

Subchapter A. Monitored In-Home Caregiving Module

§5101. General Provisions

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a client who lives in a private unlicensed residence.

1. The principal caregiver shall:

- a. be contracted by the licensed HCBS provider having a MIHC service module; and
- b. reside with the client.

2. Professional staff employed by the HCBS provider shall provide oversight, support, and monitoring of the principal caregiver, service delivery, and client outcomes through on-site visits, training, and daily web-based electronic information exchange.

B. Providers applying for the monitored in-home caregiving module under the HCBS license shall meet the core licensing requirements (except those set forth in §5005.B.4, §5005.C. and §5007.F.1.c) and the module specific requirements of this Section.

C. During any survey or investigation of the HCBS provider with the MIHC module conducted by the DHH-HSS, the survey process begins once the surveyor enters either the client's place of residence or the provider's licensed place of business. When the survey begins at the client's residence, the provider shall transmit any records requested by the HSS surveyor within two hours of such request to the location as designated by the HSS surveyor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5103. Staffing Requirements, Qualifications, and Duties

A. The MIHC provider shall employ a registered nurse (RN) and a care manager who will monitor all clients served. The RN or the care manager may also serve as the administrator if he/she meets the requirements as set forth in §5055.A.1.

B. The HCBS provider with a MIHC module shall contract with at least one principal caregiver for each client served.

1. The principal caregiver shall:

- a. serve only one client at any time; and
- b. be able to provide sufficient time to the client as required to provide the care in accordance with the ISP.

2. Prior to MIHC services being provided to the client, the HCBS provider shall perform an assessment of the client's ability to be temporarily unattended by the principal caregiver and determine how the client will manage safely in the qualified setting without the continuous presence of a principal caregiver.

C. The MIHC registered nurse shall:

1. be licensed and in good standing with the Louisiana State Board of Nursing; and

2. have at least two years' experience in providing care to the elderly or to adults with disabilities.

D. The responsibilities of the registered nurse include:

1. participating in the determination of the qualified setting for MIHC services, based on on-site assessment of the premises;

2. ensuring that the client's applicable health care records are available and updated as deemed necessary;

3. developing, in collaboration with the care manager, client and principal caregiver, the client's person-centered ISP, based upon assessment of the client and medical information gathered or provided;

4. periodically reviewing and updating, at least annually, each client's ISP;

5. certifying, training, and evaluating principal caregivers in conjunction with the care manager;

6. monitoring, through daily review of electronic client progress notes, observation of at-home visits, and by documented consultations with other involved professionals, the status of all clients to ensure that MIHC services are delivered in accordance with the ISP;

7. conducting on-site visits with each client at the qualified setting at least every other month or more often as deemed necessary by the client's health status;

8. completing a nursing progress note corresponding with each on-site visit or more often as deemed necessary by the client's health status; and

9. planning for, and implementing, discharges of clients from MIHC services relative to if the health care needs of the client can be met in the qualified setting.

E. MIHC Care Manager Qualifications

1. The MIHC care manager shall meet one of the following requirements:

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

b. possess a bachelor's or master's degree in nursing (RN) currently licensed in Louisiana (one year of experience as a licensed RN will substitute for the degree);

c. possess a bachelor's or master's degree in a human service related field which includes:

i. psychology;

ii. education;

iii. counseling;

iv. social services;

v. sociology;

vi. philosophy;

vii. family and participant sciences;

viii. criminal justice;

ix. rehabilitation services;

x. substance abuse treatment;

xi. gerontology; or

xii. vocational rehabilitation; or

d. possess a bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields in §5103.E.1.c.i-xii.

2. The MIHC care manager shall have at least two years' experience in providing care to the elderly or to adults with disabilities.

3. The MIHC care manager may serve as the administrator of the HCBS provider; however, any such individual that serves as both administrator and care manager shall meet both sets of minimum qualifications and have the ability to service both sets of specified functions.

F. Care Manager Responsibilities. The following responsibilities of the care manager for the MIHC module shall substitute for the requirements in §5055.I and §5055.J. The responsibilities of the MIHC care manager shall include:

1. conducting the initial and ongoing assessment and determination of the qualified setting;

2. certifying, training, and evaluating principal caregivers in conjunction with the registered nurse;

3. developing, in collaboration with the registered nurse, an ISP for delivery of MIHC services for each client, based upon assessment and medical information gathered or provided;

4. monitoring, in collaboration with the registered nurse, through daily review of electronic client progress notes, and observation of at-home visits, the status of all clients to ensure that all MIHC services are delivered;

5. conducting on-site visits with each client at the qualified setting every other month or more often as deemed necessary by the client's health status;

6. completing a care management client progress note corresponding with each on-site visit every other month or more often as the client's condition warrants;

7. assisting with obtaining information and accessing other health-care and community services in accordance with the ISP;

8. reviewing and documenting the fire and safety procedures for the qualified setting;

9. providing training related to MIHC services for each principal caregiver before the principal caregiver begins to provide care;

10. participating in discharge planning of clients from monitored in-home care services by determining if the needs of the client can be met safely in the qualified setting;

11. reviewing and documenting that the qualified setting continues to meet the needs of the client, in accordance with the ISP, at every on-site visit and as situations change; and

12. being readily accessible and available to the principal caregivers either by telephone or other means of prompt communication.

a. The care manager shall maintain a file on each principal caregiver which shall include documentation of each principal caregiver's performance during the care manager's bimonthly on-site visit and more often as caregiver's performance warrants.

G. MIHC Principal Caregiver Qualifications. The following principal caregiver qualifications under the MIHC module shall substitute for the requirements in §5055.F.

1. The principal caregiver shall be certified by the HCBS provider before serving a client.

2. In order to be certified, the principal caregiver applicant shall:

a. participate in all required orientations, trainings, monitoring, and corrective actions required by the HCBS provider;

b. have a criminal background check conducted by the HCBS provider in accordance with the applicable state laws;

c. comply with the provisions of R.S. 40:2179-2179.2 and the rules regarding the direct service worker registry;

d. be at least 21 years of age and have a high school diploma or equivalent;

e. have the ability to read, write, and carry out directions competently as assigned; and

f. be trained in recognizing and responding to medical emergencies of clients.

3. To maintain certification, the principal caregiver shall reside in the state of Louisiana and shall provide MIHC services in a qualified setting located in Louisiana.

H. MIHC Principal Caregiver Responsibilities. The following principal caregiver responsibilities under the MIHC module shall substitute for the responsibilities in §5055.G. The responsibilities of the principal caregiver shall include:

1. supervision and assistance with personal care services for the client that is necessary for his/her health, safety and well-being in accordance with the ISP;

2. monitoring and reporting any non-urgent or nonemergency changes in the client's medical condition to the HCBS care manager;

3. promptly reporting and communicating a client's request for services or change in services to the care manager;

4. maintaining the qualified setting consistent with the criteria noted herein;

5. completing and submitting to the HCBS agency an electronic client progress note daily;

6. providing ongoing supervision of health-related activities, including, but not limited to:

a. reminding the client about prescribed medications;

b. ensuring that the client's prescriptions are refilled timely;

c. transporting or arranging for client transportation to medical and other appointments;

d. assisting the client to comply with health care instructions from health care providers, including but not limited to, dietary restrictions;

e. recognizing and promptly arranging for needed urgent medical care by activating the 911 call system;

f. notifying the care manager of the need for alternative care of the client;

g. immediately reporting any suspected abuse, neglect, or exploitation of a client to the HCBS care manager, as well as timely reporting any suspected abuse, neglect, or exploitation of a client to any other persons required by law to receive such notice;

h. immediately notifying the care manager when any of the following events occur:

i. death of a client;

ii. a medical emergency or any significant change in a client's health or functioning;

iii. a fire, accident, and/or injury that requires medical treatment or the medical diagnosis of a reportable

communicable disease of the client and/or principal caregiver;

iv. any planned or unexpected departure from the residence by a client or principal caregiver; and

v. all other client or principal caregiver major incidents or accidents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5105. Operational Requirements for Monitored In-Home Caregiving

A. Training. The following requirements for training and competency for the MIHC module shall substitute for the training and competency requirements in §5055.K, §5055.L, and §5055.M.

1. Prior to the principal caregiver providing MIHC services to a client, the HCBS provider shall ensure that the principal caregiver satisfactorily completes documented training in the following areas:

a. the client's support needs in accordance with the ISP, including the following:

- i. medical and behavioral diagnoses;
- ii. medical and behavioral health history;
- iii. required ADLs and IADLs;
- iv. management of aggressive behaviors, including acceptable and prohibited responses; and

v. any other pertinent information;

b. completion and transmission of the daily electronic client progress note;

c. emergency and safety procedures, including the HCBS provider's fire, safety, and disaster plans;

i. this training shall include recognizing and responding to medical emergencies or other emergencies that require an immediate call to 911;

d. detection and reporting suspected abuse, neglect and exploitation, including training on the written policies and procedures of the HCBS provider regarding these areas;

e. written policies and procedures of the HCBS provider including, but not limited to:

i. documentation and provider's reporting requirements;

- ii. infection control;
- iii. safety and maintenance of the qualified setting;
- iv. assistance with medication(s);
- v. assistance with ADLs and IADLs;
- vi. transportation of clients; and
- vii. client rights and privacy;

f. confidentiality;

g. detecting signs of illness or dysfunction that warrant medical or nursing intervention; and

h. the roles and responsibilities of the HCBS staff and the principal caregiver.

2. The HCBS provider shall ensure that each principal caregiver satisfactorily completes a basic first aid course within 45 days of hire.

B. Transmission of Information

1. The HCBS provider shall use secure, web-based information collection from principal caregivers for the purposes of monitoring client health and principal caregiver performance.

2. All protected health information shall be transferred, stored, and utilized in compliance with applicable federal and state privacy laws.

3. HCBS providers shall sign, maintain on file, and comply with the most current DHH HIPAA business associate addendum.

C. Monitoring. The HCBS provider shall provide ongoing monitoring of the client and the performance of the principal caregiver in accordance with the ISP. Ongoing monitoring shall consist of the following:

1. conducting on-site visits with each client at the qualified setting monthly by either the RN or the care manager in order to monitor the health and safety status of the client and to ensure that all MIHC services are delivered by the principal caregiver in accordance with the ISP;

2. reviewing and documenting at least every other month that the qualified setting meets the needs of the MIHC services to be provided to the client in accordance with the ISP;

3. receiving and reviewing the daily electronic client progress notes to monitor the client's health status and principal caregiver's performance to ensure appropriate and timely follow up;

4. ensuring the competency of the principal caregiver by written or oral exam before providing services and annually; and

5. ensuring that each principal caregiver receives annual training to address the needs of the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5107. Qualified Setting Provisions

A. The residence where MIHC services are provided to a client shall be a qualified setting as stipulated herein. The qualified setting determination shall be completed by the HCBS provider as part of the admission process and on an on-going basis as stipulated herein.

B. In order for a setting to be determined qualified for MIHC services, the setting shall meet the following criteria:

1. is a private residence located in Louisiana, occupied by the client and a principal caregiver and shall not be subject to state licensure or certification as a hospital, nursing facility, group home, intermediate care facility for individuals with intellectual disabilities or as an adult residential care provider;

2. is accessible to meet the specific functional, health and mobility needs of the client residing in the qualified setting;

3. is in compliance with local health, fire, safety, occupancy, and state building codes for dwelling units;

4. is equipped with appropriate safety equipment, including, at a minimum, an easily accessible class ABC fire extinguisher, smoke and carbon monoxide detectors (which shall be audible in the client's and principal caregiver's sleeping areas when activated);

5. is equipped with heating and refrigeration equipment for client's meals and/or food preparation, e.g. warming or cooling prepared foods;

6. has a bedroom for the client which shall contain a bed unit appropriate to his/her size and specific needs that

includes a frame, a mattress, and pillow(s). The bedroom shall have a closeable door and window coverings to ensure privacy of the client with adequate lighting to provide care in accordance with the ISP;

7. has a closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the client or the principal caregiver;

8. has a bathroom with functioning indoor plumbing for bathing and toileting with availability of a method to maintain safe water temperatures for bathing;

9. is equipped with functional air temperature controls which maintain an ambient seasonal temperature between 65 and 80 degrees Fahrenheit;

10. is maintained with pest control;

11. is equipped with a 24 hour accessible working telephone and/or other means of communication with health care providers;

12. is equipped with household first aid supplies to treat minor cuts or burns; and

13. as deemed necessary, has secured storage for potentially hazardous items, such as fire arms and ammunition, drugs or poisons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5109. Waiver of Module Provisions

A. In its application for a license, or upon renewal of its license, a provider may request a waiver of specific MIHC module licensing provisions.

1. The waiver request shall be submitted to HSS, and shall provide a detailed description as to why the provider is requesting that a certain licensing provision be waived.

2. HSS shall review such waiver request. Upon a good cause showing, HSS, at its discretion, may grant such waiver, provided that the health, safety, and welfare of the client is not deemed to be at risk by such waiver of the provision(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have an adverse impact on the staffing level requirements or qualifications required to provide the same level of service if the provider elects to render monitored in-home caregiving services, and may increase direct or indirect cost to the provider to provide the same level of service. This proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as describe in HCR 170 if the increase in direct or indirect cost adversely impacts the provider's financial standing.

Public Comments

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Home and Community-Based Services Providers—Licensing Standards

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 15-16. It is anticipated that \$2,484(SGF) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect revenue collections since the licensing fees, in the same amounts, will continue to be collected as the number of home and community-based providers are not anticipated to change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule continues the provisions of the November 20, 2014 emergency rule which amended the provisions governing the licensing standards for home and community-based services (HCBS) providers to clarify these provisions and to include licensing provisions for monitored in-home caregiving services. It is anticipated that the implementation of this proposed rule may have economic cost

to the HCBS providers in FY 15-16, FY 16-17, and FY 17-18 should they elect to render monitored in-home caregiving services.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello
Health Standards Section Director
1509#081

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Aging and Adult Services**

Home and Community-Based Services Waivers
Community Choices Waiver
(LAC 50:XXI.8329 and 8601)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.8329 and §8601 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the Community Choices Waiver to add two new waiver services, to incorporate a new service delivery method, and to clarify the provisions governing personal assistance services (*Louisiana Register*, Volume 40, Number 4). The department promulgated an Emergency Rule which amended the provisions governing the Community Choices Waiver in order to clarify the provisions governing monitored in-home caregiving services and to revise the provisions governing the organized health care delivery system (*Louisiana Register*, Volume 40, Number 11). This proposed Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services
Waivers**

Subpart 7. Community Choices Waiver

Chapter 83. Covered Services

§8329. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a participant who lives in a private unlicensed residence. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the participant. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and participant outcomes through on-site visits, training, and daily, web-based electronic information exchange.

B. - B.6. ...

C. Unless the individual is also the spouse of the participant, the following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. - 5. ...

D. Participants electing monitored in-home caregiving services shall not receive the following community choices waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. - 3. ...

E. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the most current DHH HIPAA business associate addendum.

1. - 3. Repealed.

G. ...

1. Monitored in-home caregiving services under tier 1 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

- a. special rehabilitation 1.21;
- b. special rehabilitation 1.12;
- c. special rehabilitation 1.11;
- d. special care 3.11;
- e. clinically complex 4.31;
- f. clinically complex 4.21;
- g. impaired cognition 5.21;
- h. behavior problems 6.21;
- i. reduced physical function 7.41; and
- j. reduced physical function 7.31.

2. Monitored in-home caregiving services under tier 2 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

- a. extensive services 2.13;
- b. extensive services 2.12;
- c. extensive services 2.11; and
- d. special care 3.12.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:

**Chapter 86. Organized Health Care Delivery System
§8601. General Provisions**

A. - C. ...

D. Prior to enrollment, an OHCDs must show the ability to provide all of the services available in the Community

Choices Waiver on December 1, 2012, with the exceptions of support coordination, transition intensive support coordination, transition services and adult day health care if there is no licensed adult day health care provider in the service area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Home and Community-Based Services Waivers—Community Choices Waiver

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 15-16. It is anticipated that \$756 (\$378 SGF and \$378 FED) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 15-16. It is anticipated that \$378 will be collected in FY 15-16 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule continues the provisions of the November 20, 2014 Emergency Rule which amended the provisions governing the Community Choices Waiver in order to clarify the provisions governing monitored in-home caregiving services and to revise the provisions governing the organized health care delivery system. It is anticipated that the implementation of this proposed rule will have no economic cost or benefits to Community Choices Waiver providers in FY 15-16, FY 16-17, and FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1509#082

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Outpatient Clinics
Service Limits
(LAC 50:V.5117)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:V.5117 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

In compliance with federal regulations, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing outpatient hospital

services to remove the visit limits on emergency room services (*Louisiana Register*, Volume 40, Number 11). This Rule also ensured that these provisions were appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

The department now proposes to amend the provisions governing outpatient hospital services in order to remove the 12 visits per year limit on physician services provided in a clinic in an outpatient hospital setting.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 51. General Provisions

§5117. Service Limits

A. - A.1. ...

2. clinic services-physician services provided in a clinic in an outpatient hospital setting shall be considered physician services, not outpatient services, and there shall be no limits placed on the number of physician visits payable by the Medicaid program for eligible recipients; and

A.3. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 9:551 (August 1983), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2261 (November 2014), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 as it will allow greater access to routine physician services provided in clinics in outpatient hospital settings.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families for physician services rendered that exceed the current allowable visits per calendar year in outpatient hospital clinics.

Provider Impact Statement

In compliance with House Concurrent Resolution 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the direct or indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to

provide the same level of service since this proposed Rule may increase payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Outpatient Hospital Services Outpatient Clinics—Service Limits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 15-16 since there were no historical claims denials for physician services in an outpatient hospital setting that would have exceeded the allowable limits, removing the limits will be cost neutral. It is anticipated that \$432 (\$216 SGF and \$216 FED) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 15-16. It is anticipated that \$216 will be collected in FY 15-16 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing outpatient hospital services in order to remove the 12 visits per year limit on physician services provided in a clinic in an outpatient hospital setting. It is anticipated that the implementation of this proposed rule will have no economic cost or benefits to hospitals in FY 15-16, FY 16-17, and FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1509#083

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

Pain Management Clinics
Licensing Standards
(LAC 48:I.Chapter 78)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 48:I.Chapter 78 as authorized by R.S. 36:254 and R.S. 40:2198.11-13. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the licensing standards for pain management clinics in order to further clarify the definition of pain management specialist as related to services furnished by urgent care facilities (*Louisiana Register*, Volume 34, Number 7).

Act 714 of the 2014 Regular Session of the Louisiana Legislature directed the department to amend the provisions governing the licensing of pain management clinics to provide for the expiration of licensure exemptions and related matters. The department now proposes to amend the licensing standards governing pain management clinics to comply with Act 714, and to revise these provisions to ensure that they are consistent with the licensing standards for other health care providers and current enforcement processes.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 78. Pain Management Clinics

Subchapter A. General Provisions

§7801. Definitions

* * *

Administrator—the person responsible for the day-to-day management, supervision, and non-medical operation of the pain management clinic.

* * *

Cessation of Business—provider is non-operational and has stopped offering or providing services to the community.

* * *

DAL—Division of Administrative Law.

* * *

Health Standards Section (HSS)—the section within the Department of Health and Hospitals with responsibility for licensing pain management clinics.

* * *

Non-Operational—the pain management clinic is not open for business operation on designated days and hours as stated on the licensing application.

* * *

OPH—the Department of Health and Hospitals, Office of Public Health.

* * *

Primarily Engaged in Pain Management—during the course of any day a clinic is in operation, 51 percent or more

of the patients seen are issued a narcotic prescription for the treatment of chronic non-malignant pain. Exception: A physician who in the course of his/her own private practice shall not be considered primarily engaged in the treatment of chronic non-malignant pain by prescribing narcotic medications provided that the physician:

1. treats patients within his/her area of specialty and who utilizes other treatment modalities in conjunction with narcotic medications;
2. is certified by a member board of the American Board of Medical Specialties; and
3. ...

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:80 (January 2008), amended LR 34:1418 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7803. Ownership

A. - B.4. ...

C. A pain management clinic that is not licensed by, or has not submitted a completed application to, the department for licensure on or before August 1, 2014, shall not be licensed under the exemption to §7803.B.

1. Repealed.

D. Any change of ownership (CHOW) shall be reported in writing to the Health Standards Section within five working days of the transfer of ownership by any lawful means. The license of a clinic is not transferable or assignable between individuals, clinics or both. A license cannot be sold.

1. The new owner shall submit all documents required for a new license including the licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:80 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter B. Licensing Procedures

§7811. General Provisions

A. It shall be unlawful to operate a clinic without obtaining a license issued by the department. The department is the only licensing agency for pain management clinics in the state of Louisiana. A pain management clinic verified to be operating without a license shall be required to immediately cease and desist operation and discharge all patients.

B. A clinic shall renew its license annually. A renewal application and licensing fee shall be submitted at least 30 days before the expiration of the current license. Failure to submit a complete renewal application shall be deemed to be a voluntary termination and expiration of the facility's license. The license shall be surrendered to the department within 10 days, and the facility shall immediately discharge all patients and cease providing services.

C. - D. ...

1. Any change that requires a change in the license shall be accompanied by the required fee.

2. Any change in geographic location of the clinic requires that the provider requests, and satisfactorily meets the requirements of, the following prior to any patient receiving service at the new location:

a. plan review for life safety code and licensing and inspection report with approvals for occupancy from the Office of the State Fire Marshal (OSFM); and

b. a copy of the health inspection report with a recommendation for licensure or a recommendation for denial of licensure from the Office of Public Health (OPH); and

c. an on-site survey prior to issuance of new license by the department.

3. Exception. Pursuant to R.S. 40:2198.12(D)(1)(g), a pain management clinic which is exempted from the requirement of being owned and operated by a physician certified in the subspecialty of pain management may relocate and continue to be exempted from the requirement of being owned and operated by a physician certified in the subspecialty of pain management if the new location is in the same parish in which the original clinic was located.

E. A separately licensed clinic shall not use a name which is substantially the same as the name of another clinic licensed by the department unless the clinic is under common ownership and includes a geographic identifier.

F. The clinic shall not use a name which may mislead the patient or their family into believing it is owned, endorsed, or operated by the state of Louisiana.

G. Any request for a duplicate license shall be accompanied by the required fee.

H. A clinic intending to have controlled dangerous medications on the premises shall make application for a controlled dangerous substance (CDS) license, and shall comply with all of the federal and state regulations regarding procurement, maintenance and disposition of such medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7813. Initial Application Process

A. ...

B. To be considered complete, the initial licensing application packet shall include the following:

1. ...

2. a copy of the plan review for life safety code and licensing and the on-site inspection report with approvals for occupancy from the OSFM;

3. a copy of the health inspection report with a recommendation for licensure or a recommendation for denial of licensure from the OPH;

4. ...

5. a statewide criminal background check on all owners conducted by the Louisiana State Police or its designee;

6. verification of the physician owner's certification in the subspecialty of pain management;

7. proof of professional liability insurance of at least \$500,000;

a. proof of maintenance of professional liability insurance of at least \$500,000 shall be provided to the department at the time of initial licensure, at renewal of licensure, and upon request;

8. an organizational chart identifying the name, position, and title of each person composing the governing body and key administrative personnel;

9. a floor sketch or drawing of the premises to be licensed; and

10. any other documentation or information required by the department for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7815. Licensing Surveys

A. - B. ...

C. The department may conduct a complaint investigation in accordance with R. S. 40:2009.13, et seq. for any complaint received against a clinic. A complaint survey shall be unannounced to the clinic.

D. A follow-up survey may be done following any licensing survey or any complaint survey to ensure correction of a deficient practice cited on the previous survey. Such surveys shall be unannounced to the clinic.

E. Following any survey, the pain management clinic shall receive a statement of deficiencies documenting relevant findings, including the deficiency, the applicable governing rule, and the evidence supporting why the rule was not met.

1. The following statements of deficiencies issued by the department to the pain management clinic must be posted in a conspicuous place on the licensed premises:

a. the most recent annual licensing survey statement of deficiencies; and

b. any follow-up and/or complaint survey statement of deficiencies issued after the most recent annual licensing survey.

2. Any statement of deficiencies issued by the department to a pain management clinic shall be available for disclosure to the public within 30 calendar days after the pain management clinic submits an acceptable plan of correction to the deficiencies or within 90 days of receipt of the statement of deficiencies, whichever occurs first.

F. The department may require a plan of correction from a pain management clinic following any survey wherein deficiencies have been cited. The fact that a plan of correction is accepted by the department does not preclude the department from pursuing other actions against the pain management clinic as a result of the cited deficiencies.

G. The applicant and/or pain management clinic shall have the right to request an informal reconsideration of any deficiencies cited during any initial licensing survey, annual licensing survey, and follow-up survey.

1. The request for an informal reconsideration must be in writing and received by HSS within 10 calendar days of receipt of the statement of deficiencies. If a timely request for an informal reconsideration is received, HSS shall

schedule the informal reconsideration and notify the pain management clinic in writing.

a. The request for an informal reconsideration does not delay submission of the plan of correction within the prescribed timeframe.

2. The request for an informal reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

3. Correction of the deficiency or deficiencies cited in any survey shall not be the basis for an informal reconsideration.

4. The pain management clinic may appear in person at the informal reconsideration and may be represented by counsel.

5. The pain management clinic shall receive written notice of the results of the informal reconsideration.

6. The results of the informal reconsideration shall be the final administrative decision regarding the deficiencies and no right to an administrative appeal shall be available.

H. Complaint Survey Informal Reconsideration. Pursuant to R.S. 40:2009.13 et seq., a pain management clinic shall have the right to request an informal reconsideration of the validity of the deficiencies cited during any complaint survey, and the complainant shall be afforded the opportunity to request an informal reconsideration of the survey findings.

1. The department shall conduct the informal reconsideration by administrative desk review.

2. The pain management clinic and/or the complainant shall receive written notice of the results of the informal reconsideration.

3. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the results of the informal reconsideration shall be the final administrative decision and no right to an administrative appeal shall be available.

I. Sanctions. The department may impose sanctions as a result of deficiencies cited following any survey. A sanction may include, but is not limited to:

1. civil fine(s);
2. revocation of license;
3. denial of license renewal;
4. immediate suspension of license; and
5. any and all sanctions allowed under federal or state law or regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7817. Issuance of Licenses

A. ...

B. A full pain management clinic license may be issued only to applicants that are in compliance with all applicable federal, state and local laws and regulations. This license shall be valid until the expiration date shown on the license, unless the license has been revoked, terminated, or suspended.

C. A provisional license may be issued to those existing licensed pain management clinics that do not meet the criteria for full licensure. This license shall be valid for no

more than six months, unless the license has been revoked, terminated, or suspended.

1. - 1.d. ...

2. A pain management clinic with a provisional license may be issued a full license if at the follow-up survey the clinic has corrected the deficient practice. A full license may be issued for the remainder of the year until the clinic's license anniversary date.

3. The department may re-issue a provisional license or allow a provisional license to expire when the clinic fails to correct deficient practice within 60 days of being cited or at the time of the follow-up survey, whichever occurs first.

4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:82 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7819. Initial License Denial, License Revocation or Denial of License Renewal

A. - A.3. ...

B. A pain management clinic license may not be renewed or may be revoked for any of the following reasons, including but not limited to:

1. - 6. ...

7. failure to remain operational on the days, and during the hours, the clinic has reported to the department that it will be open, unless the closure is unavoidable due to a man-made or natural disaster and in accordance with §7825;

8. - 10. ...

11. failure to correct areas of deficient practice;

B.12. - C. ...

D. When a clinic is under a denial of license renewal action, provisional licensure, or license revocation action, that clinic is prohibited from undergoing a change of ownership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:82 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7821. Notice and Appeal Procedures

A. ...

1. The notice shall specify reasons for the action and shall notify the applicant or clinic of the right to request an administrative reconsideration or to request an appeal. A voluntary termination or expiration of the license is not an adverse action and is not appealable.

A.2. - B. ...

1. A request for an administrative reconsideration shall be submitted in writing to the Health Standards Section within 15 calendar days of receipt of notification of the department's action.

2. ...

a. - a.iv. Repealed.

2.b. - 4....

5. An administrative reconsideration is not in lieu of the administrative appeals process.

C. Administrative Appeal Process. Upon denial or revocation of a license by the department, the clinic shall have the right to appeal such action by submitting a written request to the Division of Administrative Law (DAL), or its successor, within 30 days after receipt of the notification of the denial or revocation of a license, or within 30 days after receipt of the notification of the results of the administrative reconsideration.

1. Correction of a deficiency shall not be the basis of an administrative appeal.

2. ...

a. The clinic which is adversely affected by the action of the department in immediately revoking a license may, within 30 days of the closing, devolutively appeal from the action of the department by filing a written request for a hearing to the DAL or its successor.

D. If an existing licensed pain management clinic has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. The denial of the license renewal application does not affect in any manner the license revocation.

2. If the final decision by the DAL or its successor is to reverse the initial license denial, the denial of license renewal, or the license revocation, the provider's license will be reinstated or granted upon the payment of any licensing or other fees due to the department.

E. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license. An existing provider who has been issued a provisional license remains licensed and operational and also has no right to an administrative reconsideration or an administrative appeal. The issuance of a provisional license to an existing pain management clinic is not considered to be a denial of license, a denial of license renewal, or a license revocation.

1. A follow-up survey may be conducted prior to the expiration of a provisional initial license to a new pain management clinic or the expiration of a provisional license to an existing provider.

2. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

3. If all noncompliance or deficiencies have not been corrected at the time of the follow-up survey, or if new deficiencies that are a threat to the health, safety, or welfare of residents are cited on the follow-up survey, the provisional initial license or provisional license shall expire on its face and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

4. The department shall issue written notice to the clinic of the results of the follow-up survey.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an administrative reconsideration and the right to an administrative appeal of the deficiencies cited at the follow-up survey.

a. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis

for the administrative reconsideration or for the administrative appeal.

b. The administrative reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The provider must request the administrative reconsideration of the deficiencies in writing, which shall be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

d. The provider must request the administrative appeal within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

e. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Section must cease providing services unless the DAL or its successor issues a stay of the expiration. The stay may be granted by the DAL or its successor upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing, and only upon a showing that there is no potential harm to the residents being served by the pain management clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:83 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7823. Cessation of Business

A. Except as provided in §7825 of these licensing regulations, a license shall be immediately null and void if a pain management clinic becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the pain management clinic stopped offering or providing services to the community.

C. Upon the cessation of business, the pain management clinic shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the pain management clinic. The clinic does not have a right to appeal a cessation of business.

E. The pain management clinic shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the provider shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;
2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's patients medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing clinic, at least 15 days prior to the effective date of closure.

F. Failure to comply with the provisions concerning submission of a written plan for the disposition of patient medical records to the Department may result in the provider being prohibited from obtaining a license for any provider type issued by the department.

G. Once the pain management clinic has ceased doing business, the provider shall not provide services until the clinic has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7825. Inactivation of License due to Declared Disaster or Emergency

A. A licensed pain management clinic in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed two years, provided that the following conditions are met:

1. the licensed pain management clinic shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the pain management clinic has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed pain management clinic intends to resume operation as a pain management clinic in the same service area; and

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

NOTE: Pursuant to these provisions, an extension of the 60-day deadline may be granted at the discretion of the department.

2. the licensed pain management clinic resumes operating as a pain management clinic in the same service area within two years of the approval of construction plans by all required agencies upon issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed pain management clinic continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

4. the licensed pain management clinic continues to submit required documentation and information to the department, including but not limited to cost reports.

B. Upon receiving a completed written request to inactivate a pain management clinic license, the department shall issue a notice of inactivation of license to the pain management clinic.

C. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a pain management clinic which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the pain management clinic shall submit a written license reinstatement request to the licensing agency of the department within two years of the executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey; and

3. the license reinstatement request shall include a completed licensing application with the appropriate licensing fees.

D. Upon receiving a completed written request to reinstate a pain management clinic license, the department shall conduct a licensing survey. If the pain management clinic meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the pain management clinic license.

E. No change of ownership in the pain management clinic shall occur until such pain management clinic has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a pain management clinic.

F. The provisions of this Section shall not apply to a pain management clinic which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the pain management clinic license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter C. Clinic Administration

§7831. Medical Director

A. - B. ...

1. A licensed pain management clinic which has been verified by the department as being in operation on or before June 15, 2005, is required to have a medical director, but is exempt from having a medical director who is certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties.

C. Responsibilities. The medical director is responsible for the day-to-day clinical operation and shall be on-site, at a minimum, 50 percent of the time during the operational hours of the clinic. When the medical director is not on-site during the hours of operation, then the medical director shall be available by telecommunications and shall be able to be on-site within 30 minutes.

1. ...

2. The medical director shall ensure that all qualified personnel perform the treatments or procedures for which each is assigned. The clinic shall retain documentation of staff proficiency and training.

3. The medical director, or his designee, is responsible for ensuring a medical referral is made to an addiction facility, when it has been determined that a patient has been diverting drugs or participating in the illegal use of drugs.

4. ...

5. The medical director shall ensure that patients are informed of after-hours contact and treatment procedures.

6. ...

a. The PMP is to be utilized by the medical director and the pain specialist as part of the clinic's quality assurance program to ensure adherence to the treatment agreement signed by the patient.

i. - i.(a). ...

b. Compliance to this agreement is to be determined, evaluated, and documented at each subsequent visit to a clinic when the patient receives a prescription for a controlled dangerous substance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:83 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7832. Administrator

A. The pain management clinic shall have an administrator designated by the governing body who is responsible for the day-to-day management, supervision, and non-medical operation of the clinic. The administrator shall be available during the designated business hours. The provisions of this Chapter do not prohibit the medical director dually serving as the administrator.

1. Qualifications. The administrator shall be at least 18 years of age and possess a high school diploma or equivalent.

2. The pain management clinic shall designate a person to act in the administrator's absence, and shall ensure this person meets the qualifications of the administrator pursuant to this Chapter. The pain management clinic shall maintain documentation on the licensed premises identifying this person and evidence of their qualifications.

3. Duties and Responsibilities. The administrator shall be responsible for:

a. employing licensed and non-licensed qualified personnel to provide the medical and clinical care services to meet the needs of the patients being served;

b. ensuring that upon hire and prior to providing care to patients, each employee is provided with orientation, training, and evaluation for competency as provided in this Chapter;

c. ensuring that written policies and procedures for the management of medical emergencies are developed, implemented, monitored, enforced, and annually reviewed, and readily accessible to all staff;

d. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The pain management clinic shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

e. maintaining current credentialing and/or personnel files on each employee that shall include documentation of the following:

i. a completed employment application;

ii. job description;

iii. a copy of current health screening reports conducted in accordance with the clinic's policies and procedures and in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, and regulations;

iv. documentation that each employee has successfully completed orientation, training, and evaluation for competency related to each job skill as delineated in their respective job description; and

v. documentation that all licensed nurses, if employed, shall:

(a) have successfully completed a Basic Life Support course; and

(b) be in good standing and hold current licensure with their respective state nurse licensing board;

f. ensuring all credentialing and/or personnel files are current and maintained on the licensed premises at all times, including but not limited to, documentation of employee health screening reports; and

g. ensuring that appropriate law enforcement agency(s) are notified when it has been determined that a staff member has been diverting drugs or participating in the illegal use of drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7833. Clinic Operations

A. A licensed pain management clinic shall establish and implement policies and procedures consistent with all pain management rules and regulations issued by the board.

B. A licensed pain management clinic shall verify the identity of each patient who is seen and treated for chronic pain management and who is prescribed a controlled dangerous substance.

C. A licensed pain management clinic shall establish practice standards to assure quality of care, including but not limited to, requiring that a prescription for a controlled dangerous substance may have a maximum quantity of a 30 day supply and shall not be refillable.

D. On each visit to the clinic which results in a controlled dangerous substance being prescribed to a patient, the patient shall be personally examined by a pain specialist and such shall be documented in the patient's clinical record.

E. A pain management clinic shall have enough qualified personnel who are available to provide direct patient care as needed to all patients and to provide administrative and nonclinical services needed to maintain the operation of the clinic in accordance with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7835. Governing Body

A. A pain management clinic shall be in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances.

B. A pain management clinic shall have a governing body that assumes full responsibility for the total operation of the pain management clinic.

1. The governing body shall consist of at least one individual who assumes full responsibility.

2. The pain management clinic shall maintain documentation on the licensed premises identifying the following information for each member of the governing body:

- a. name;
- b. contact information;
- c. address; and
- d. terms of membership.

3. The governing body shall develop and adopt bylaws which address its duties and responsibilities.

4. The governing body shall, at minimum, meet annually and maintain minutes of such meetings documenting the discharge of its duties and responsibilities.

C. The governing body shall be responsible for:

1. ensuring the pain management clinic's continued compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees;

2. designating a person to act as the administrator and delegating sufficient authority to this person to manage the non-medical day-to-day operations of the facility;

a. provisions of this Chapter do not prohibit the medical director dually serving as the administrator with responsibility for both medical and non-medical operations of the clinic;

3. designating a person to act as the medical director and delegating authority to this person to allow him/her to direct the medical staff, nursing personnel, and medical services provided to each patient consistent with all pain management rules and regulations issued by the Board;

4. evaluating the administrator and medical director's performance annually, and maintaining documentation of such in their respective personnel files;

5. ensuring that upon hire and prior to providing care to patients, and annually thereafter, each employee is provided with orientation, training, and evaluation for competency according to their respective job descriptions in accordance with the provider's policies and procedures;

6. developing, implementing, enforcing, monitoring, and annually reviewing in collaboration with the administrator and medical director written policies and procedures governing the following:

- a. the scope of medical services offered;
- b. personnel practices, including, but not limited to:
 - i. developing job descriptions for licensed and non-licensed personnel consistent with the applicable scope of practice as defined by federal and state law;
 - ii. developing a program for orientation, training, and evaluation for competency; and
 - iii. developing a program for health screening;
- c. the management of medical emergencies; and
- d. disaster plans for both internal and external occurrences;

7. approving all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations;

8. ensuring all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations are maintained on the licensed premises and readily accessible to all staff;

9. maintaining organization and administration of the pain management clinic;

10. acting upon recommendations from the medical director relative to appointments of persons to the medical staff;

11. ensuring that the pain management clinic is equipped and staffed to meet the needs of its patients;

12. ensuring services that are provided through a contract with an outside source, if any, are provided in a safe and effective manner;

13. ensuring that the pain management clinic develops, implements, monitors, enforces, and reviews at a minimum, quarterly, a quality assurance and performance improvement (QA) program;

14. developing, implementing, monitoring, enforcing, and annually reviewing written policies and procedures relating to communication with the administrator, medical director, and medical staff to address problems, including, but not limited to, patient care, cost containment, and improved practices;

15. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The pain management clinic shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

16. ensuring that the pain management clinic procures emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care;

17. ensuring that the pain management clinic orders and maintains a supply of emergency drugs for stabilizing and/or treating medical conditions on the licensed premises, subject to approval by the medical director; and

18. ensuring that the pain management clinic develops, implements, enforces, monitors, and annually reviews written policies and procedures to ensure compliance with all applicable federal, state, and local statutes, laws, ordinances, and department rules and regulations, including but not limited to, appropriate referrals when it has been determined that a patient or staff member has been diverting drugs or participating in the illegal use of drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7837. Orientation and Training

A. Orientation and Training. The administrator shall develop, implement, enforce, monitor, and annually review, in collaboration with the medical director, written policies and procedures regarding orientation and training of all employees.

1. Orientation. Upon hire and prior to providing care to patients, all employees shall be provided orientation

related to the clinic's written policies and procedures governing:

- a. organizational structure;
- b. confidentiality;
- c. grievance process;
- d. disaster plan for internal and external occurrences;
- e. emergency medical treatment;
- f. program mission;
- g. personnel practices;
- h. reporting requirements; and
- i. basic skills required to meet the health needs of the patients.

2. Training. Upon hire, and at a minimum, annually, all employees shall be provided training in each job skill as delineated in their respective job description.

a. Medical training of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

b. Training of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with the applicable standards of practice.

c. All training programs and materials used shall be available for review by HSS.

d. The administrator shall maintain documentation of all of the training provided in each employee's personnel files.

B. Evaluation for Competency. Upon hire, and at a minimum, annually, the clinic shall conduct an evaluation for competency of all employees related to each job skill as delineated in their respective job description.

1. The evaluation for competency shall include the observation of job skills and return demonstration by the employee.

2. Evaluation for competency of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

3. Evaluation for competency of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with their applicable scope of practice.

4. The administrator shall maintain documentation of all evaluations for competencies in each employee's personnel file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter D. Facility Requirements

§7843. Facility Inspections

A. A licensed pain management clinic shall successfully complete all of the required inspections and maintain a current file of reports and other documentation that is readily available for review demonstrating compliance with all applicable laws and regulations. The inspections shall indicate current approval for occupancy.

A.1. - B. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7845. Physical Environment

A. A licensed pain management clinic shall be constructed, arranged and maintained to ensure the safety and well-being of the clinic's patients and the general public.

B. The clinic premises shall meet the following requirements including, but is not limited to:

1. a sign maintained on the clinic premises that can be viewed by the public which shall contain, at a minimum, the:

- a. ...
- b. days and hours of operation;

2. - 6. ...

C. Administrative and public areas of the clinic shall include at least the following:

1. a reception area;

2. ...

3. at least one multipurpose room large enough to accommodate family members for consultations or for staff meetings, in addition to treatment rooms;

4. designated rooms or areas for administrative and clerical staff to conduct business transactions, store and secure records, and carry out administrative functions separate from public areas and treatment areas;

5. filing cabinets and storage for providers utilizing paper medical records; such records shall be protected from theft, fire, and unauthorized access and having provisions for systematic retrieval of such records;

6. electronic medical records keeping systems for providers utilizing electronic records, such equipment shall be protected from unauthorized access and having provisions for systematic retrieval of such records; and

7. secured storage facilities for supplies and equipment.

8. - 11. Repealed.

D. - D.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7847. Infection Control Requirements

A. A pain management clinic shall have written policies and procedures, annually reviewed and signed by the medical director, to address the following:

A.1. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:85 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7849. Health and Safety Requirements

A. ...

1. The environment of the clinic shall ensure patient dignity and confidentiality.

A.2. - B.4. ...

5. post emergency telephone numbers by all telephones.

C. The clinic shall take all necessary precautions to protect its staff, patients and visitors from accidents of any nature.

D. - E. ...

1. At least one employee on-site at each clinic shall be certified in basic cardiac life support (BCLS) and be trained in dealing with accidents and medical emergencies until emergency medical personnel and equipment arrive at the clinic.

2. A licensed pain management clinic shall have first aid supplies which are easily accessible to the clinic staff.

3. ...

a. emergency medications, as designated by the medical director; and

b. any emergency medical supplies deemed necessary by the medical director and/or the governing body.

b.i. - d. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:85 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§7851. Quality Assurance

A. A licensed pain management clinic, with active participation of its medical staff, shall conduct an ongoing, comprehensive quality assurance (QA) program which shall be a self-assessment of the quality of care provided at the clinic. Quality indicators shall be developed to track and trend potential problematic areas. These quality indicators shall include, at a minimum, the following:

1. ...

2. any significant adverse effects of medical treatment or medical therapy, including the number of overdoses of prescribed medications or the number of deaths resulting from such overdoses, or both;

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:86 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter E. Patient Records

§7861. Patient Records

A. - A.1. ...

a. Safeguards shall be established to maintain confidentiality and protection of the medical record, whether stored electronically or in paper form, from fire, water, or other sources of damage and from unauthorized access.

2. - 3. ...

a. remain in the custody of the clinic, whether stored in paper form or electronically, in clinic or off-site; and

b. be readily available to department surveyors as necessary and relevant to complete licensing surveys or investigations.

c. Repealed.

B. - B.1.j. ...

k. progress or treatment notes;

1. nurses' notes of care, if any, including progress notes and medication administration records;

m. - q. ...

i. has been informed and agrees to obtain and receive narcotic prescriptions only from the licensed pain management clinic where he is receiving treatment for chronic pain;

1.q.ii. - 3. ...

4. Progress Notes. All pertinent assessments, treatments and medications given to the patient shall be recorded in the progress notes. All other notes, relative to specific instructions from the physician, shall also be recorded.

B.5. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:86 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Statement

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have an adverse impact on small businesses, as described in R.S. 49:965.2 et seq., if the requirements of these licensing changes increases the financial burden on providers. With the resources available to the department, a regulatory flexibility analysis has been prepared in order to consider methods to minimize the potential adverse impact on small businesses. The department has determined that there is no less intrusive or less costly alternative methods of achieving the intended purpose since the changes result from legislative mandates.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service and no direct or indirect cost to the provider to provide the same level of service. These provisions will have no impact

the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Pain Management Clinics
Licensing Standards**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 15-16. It is anticipated that \$5,184(SGF) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect revenue collections since the licensing fees, in the same amounts, will continue to be collected.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing the licensing of pain management clinics to provide for the expiration of licensure exemptions and related matters in compliance with Act 714 of the 2014 Regular Session of the Louisiana Legislature, and to revise these provisions to ensure that they are consistent with licensing standards for other health care providers and current enforcement processes. It is anticipated that implementation of this proposed rule will have no economic costs or benefits to pain management clinics for FY 15-16, FY 16-17, and FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello
Health Standards Section Director
1509#084

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

Professional Services Program
Physician Services
Outpatient Physician Visits
(LAC 50:IX.Chapter 6)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to repeal the September 20, 1975 Rule governing physician visits, and to adopt LAC 50:IX.Chapter 6 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Louisiana Health and Human Resources Administration, Division of Family Services promulgated a Rule governing physician services that limited the number of payable visits for medically necessary physician services for each Medicaid eligible person to 12 visits per calendar year, with provisions for extensions (*Louisiana Register*, Volume 1, Number 9).

The Department of Health and Hospitals, Bureau of Health Services Financing now proposes to repeal the September 20, 1975 Rule governing physician visits, and to adopt provisions in the Professional Services Program governing physician services in order to remove the limits from outpatient physician visits. This proposed Rule will also ensure that these provisions are promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part IX. Professional Services Program

Subpart 1. General Provisions

Chapter 6. Outpatient Physician Services

§601. General Provisions

A. The Medicaid program provides coverage and reimbursement for outpatient physician visits in the Professional Services Program. There shall be no limits placed on the number of physician visits payable by the Medicaid program for eligible recipients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family

functioning, stability and autonomy as described in R.S. 49:972 as this proposed Rule will allow greater access to physician services.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families for physician services rendered that exceed the current allowable visits per calendar year.

Provider Impact Statement

In compliance with House Concurrent Resolution 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the direct and indirect cost to the provider to provide the same level of service, and may enhance the provider’s ability to provide the same level of service since this proposed Rule may increase payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Professional Services Program Physician Services—Outpatient Physician Visits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of \$5,917 for FY 15-16, \$11,911 for FY 16-17, and \$12,127 for FY 17-18. It is anticipated that \$432 (\$216 SGF and \$216 FED) will be expended in FY 15-16 for the state’s administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the last nine months of FY 16 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$9,584 for FY 15-16, \$19,491 for FY 16-17, and \$19,846 for FY 17-18. It is anticipated that \$216 will be expended in FY 15-16 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 16 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule repeals the September 20, 1975 Rule governing physician visits, adopts provisions in the Professional Services Program governing physician services in order to remove the limits from outpatient physician visits, and ensures that these provisions are promulgated in a codified format for inclusion in the Louisiana Administrative Code. It is anticipated that implementation of this proposed rule will increase programmatic expenditures in the Medicaid Program for physician services by approximately \$15,069 for FY 15-16, \$31,402 for FY 16-17, and \$31,973 for FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition. However, it is anticipated that the implementation of this proposed rule may have a positive effect on employment as it will increase the payments made to providers. The increase in payments may improve the financial standing of physicians and could possibly cause an increase in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1509#085

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Chapter 7, of Health and Hospitals
Bureau of Health Services Financing**

Rural Health Clinics
Service Limits
(LAC 50:XI.16303)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XI.16303 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing rural health clinics (RHCs) in order to adopt provisions for the coverage of fluoride varnish application services rendered to Medicaid recipients. (*Louisiana Register*, Volume 40, Number 1).

The department now proposes to amend the provisions governing RHC service limits in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 15. Rural Health Clinics
Chapter 163. Services [Formerly Chapter 165]
§16303. Service Limits [Formerly §16503]

A. There shall be no limits placed on rural health clinic visits (encounters) payable by the Medicaid program for eligible recipients.

B. - B.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it will allow greater access to routine physician services at rural health clinics.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families for services rendered that exceed the current allowable visits per calendar year.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service since this proposed Rule may increase payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, October 29, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**
RULE TITLE: Rural Health Clinics—Service Limits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of \$374 for FY 15-16, \$326 for FY 16-17, and \$336 for FY 17-18. It is anticipated that \$432 (\$216 SGF and \$216 FED) will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the last nine months of FY 16 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$475 for FY 15-16, \$533 for FY 16-17, and \$549 for FY 17-18. It is anticipated that \$216 will be expended in FY 15-16 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 16 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing rural health clinic services in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older. It is anticipated that implementation of this proposed rule will increase programmatic expenditures in the Medicaid program for rural health clinic services by approximately \$417 for FY 15-16, \$859 for FY 16-17, and \$885 for FY 17-18.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition. However, it is anticipated that the implementation of this proposed rule may have a positive effect on employment as it will increase the payments made to providers. The increase in payments may improve the financial standing of RHCs and could possibly cause an increase in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1509#086

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of Behavioral Health

Drug Regulations
Opioid Antagonist Administration
(LAC 49:I.1199)

The Department of Health and Hospitals, Office of Behavioral Health proposes to adopt LAC 49:I.Chapter 11, 1199 governing opioid antagonist administration and training as authorized by R.S. 40:978.2. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. Act 192 of the 2015 Regular Session of the Louisiana Legislature provides for the creation of R.S. 40:978.2, which requires the Department of Health and Hospitals, Office of Behavioral Health to adopt provisions governing the best practices, training, storage, administration, and emergency follow-up procedures for opioid antagonists administered to individuals who are undergoing or who are believed to be undergoing an opioid-related drug overdose.

Title 49

PUBLIC HEALTH—FOOD AND DRUGS

Part I. Food, Drugs, and Cosmetics

Chapter 11. Drug Regulations

§1199. Opioid Antagonist Administration and Training

A. Purpose and Applicability

1. Pursuant to R.S. 40:978.2, to protect public health and safety, the Department of Health and Hospitals sets forth the following training and monitoring requirements for a licensed medical practitioner who prescribes, dispenses, or administers naloxone or another opioid antagonist to a person reasonably believed to be undergoing an opioid-related drug overdose.

2. Training and monitoring requirements of this Rule shall apply to licensed medical practitioners when dispensing or distributing opioid antagonists to third parties who will be administering the medication. Training shall include how to recognize signs of overdose indicating when it is appropriate to utilize naloxone or another opioid antagonist, standards for storage and administration of the medication, and instructions for emergency follow-up procedures.

3. First responders as defined in R.S. 40:978.1 are exempt from the training requirements as detailed in this Rule.

4. Prescribers are strongly encouraged to co-prescribe naloxone or another opioid antagonist once in a given year to persons receiving opioid therapy for greater than 14 days.

B. Definitions

Department—the Department of Health and Hospitals.

Licensed Medical Practitioner—a physician or other healthcare practitioner licensed, certified, registered, or otherwise authorized to perform specified healthcare services consistent with state law.

Opioid Antagonist—agents such as naloxone that have high affinity and bind to opiate receptors but do not activate these receptors. This effectively blocks the receptor, preventing the body from responding to opioids and endorphins. These drugs block the effects of externally administered opioids.

Opioid-Related Overdose—a condition including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or the ceasing of respiratory or circulatory function resulting from the consumption or use of an opioid, or another substance with which an opioid was combined.

SAMHSA—the Substance Abuse and Mental Health Services Administration.

Toolkit—the SAMHSA Opioid Overdose Toolkit. Reference available online through SAMHSA's website.

C. Training Requirements

1. At minimum, licensed medical practitioners shall provide the following information and training regarding signs of overdose when prescribing, distributing, or dispensing an opioid antagonist:

a. Signs of overdose, which often results in death if not treated, include:

i. Face is extremely pale and/or clammy to the touch.

ii. Body is limp.

iii. Fingernails or lips have a blue or purple cast.

iv. The patient is vomiting or making gurgling noises.

v. He or she cannot be awakened from sleep or is unable to speak.

vi. Breathing is very slow or stopped.

vii. Heartbeat is very slow or stopped.

b. Signs of overmedication, which may progress to overdose, include:

i. Unusual sleepiness or drowsiness;

ii. Mental confusion, slurred speech, intoxicated behavior;

iii. Slow or shallow breathing;

iv. Pinpoint pupils;

v. Slow heartbeat, low blood pressure; and

vi. Difficulty waking the person from sleep.

c. For additional guidance and information, please reference the most recent version of the SAMHSA Opioid Overdose Toolkit.

2. At minimum, licensed medical practitioners shall provide the following information and training regarding storage and administration when prescribing, distributing, or dispensing an opioid antagonist:

a. Instructions on storage of the opioid antagonist in accordance with the manufacturer instructions.

b. Instructions on administration of the opioid antagonist in accordance with the instructions printed on or distributed with the device by the manufacturer.

3. At minimum, licensed medical practitioners shall provide the following information and training regarding emergency and follow-up procedures when dispensing or prescribing an opioid antagonist:

a. Prior to administration, the person administering the opioid antagonist shall immediately call 9-1-1 for emergency medical services if medical assistance has not yet been sought or is not yet present.

b. After calling for emergency services and administering the opioid antagonist, emergency follow-up procedures shall be conducted in accordance with the guidelines set forth in the SAMHSA Opioid Overdose Toolkit.

c. Upon stabilization by emergency medical services, the treating practitioner shall refer the patient to and offer information regarding substance use treatment services.

G. Monitoring

1. Pharmacists dispensing naloxone or other opioid antagonists shall maintain a record of persons receiving training prior to the dispensing of the medication as per this Chapter, including recipient's acknowledgement by signature. Records shall be retained in accordance with the prescriber's scope of practice requirements.

2. Other licensed medical practitioners prescribing or distributing naloxone or other opioid antagonists shall maintain a record of persons receiving training as per this Chapter including recipient's acknowledgement by signature. Training shall be completed prior to prescribing or distributing the medication. Records shall be retained in accordance with the practitioner's scope of practice requirements.

3. Training records will be subject to monitoring and audit by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:978.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Behavioral Health, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 by assuring training at no additional cost and the safe administration of opioid antagonists during potential overdose situations, thereby saving lives and preserving the family unit. Subsequent follow-up procedures will require families to be linked to local substance use treatment options that will also serve to maintain the family unit.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973. Training will be completed upon dispensing or distribution of the opioid antagonist at no additional cost to the recipient.

Small Business Statement

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will not have an adverse impact on small businesses, as described in R.S. 49:965.2 et seq. Record keeping shall include pharmacies and licensed medical practitioners dispensing or distributing opioid antagonists maintaining files that recipients have been trained according to the proposed Rule and are subject to audit by the department.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has

been considered. It is anticipated that this proposed Rule will have a minimal impact on providers as described in HCR 170. Staffing and costs are not anticipated to be impacted, however, minor recordkeeping requirements may create a minimal workload increase to providers.

Public Comments

Interested persons may submit written comments to Jen Katzman, Office of Behavioral Health, P.O. Box 4049, Baton Rouge, LA 70821 or by email to jennifer.katzman@la.gov. Jen Katzman is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on October 12, 2015.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Drug Regulations Opioid Antagonist Administration

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that \$1,704 in state general funds will be expended in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule. The proposed rule implements the requirements of Act 192 of the 2015 Regular Session to set forth best practice training requirements by licensed medical practitioners other than first responders, on distribution, storage, administration, and emergency follow-up procedures for opioid antagonists administered to individuals who are undergoing or who are believed to be undergoing an opioid-related overdose. There are no anticipated programmatic costs resulting from implementation of training requirements detailed in the proposed rule.

For Local Governing Entities (LGEs) that opt to distribute naloxone or other opioid antagonists to clients, they will have to maintain a training log of persons receiving the medication. It is anticipated that this function can be absorbed within current LGE workload and staff.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no anticipated impact on revenue collections to state or local governing entities as a result of the proposed rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Licensed medical practitioners may encounter a minimal workload increase to provide training and maintain a record that recipients of the medication have been trained according to the Rule, which shall be available for DHH audit upon request. The practitioner shall retain this log with any other records it is required to maintain in accordance with their scope of practice.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated impact on competition and employment resulting from the proposed rule.

Jeff Reynolds
Undersecretary
1509#020

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

Disease Reporting Requirements/Anti-Rabies
Vaccination Requirements for Dogs and Cats
(LAC 51:II.105, 107, 109, 111, 113;
III.103; XVII.501; and XXI.105)

Notice is hereby given, in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., that the state health officer acting through the Department of Health and Hospitals, Office of Public Health (DHH-OPH), pursuant to the authority in R.S. 40:4(A)(2), and R.S. 40:5, intends to amend and revise Title 51 (Public Health—Sanitary Code), Part II (The Control of Diseases). The proposed amendments to Part II are regarding disease reporting requirements. The amendments to Part II require disease reporting requirement provisions currently contained in Part XVII (Public Buildings, Schools, and Other Institutions) and in Part XXI (Day Care Centers and Residential Facilities) to be updated as well. In addition, the state health officer acting through the DHH-OPH, pursuant to the authority in R.S. 40:4(A)(2) and R.S. 40:1277, also intends to amend and revise Title 51, Part III (The Control of Rabies and Other Zoonotic Diseases). This proposed amendment relates to the appropriate re-vaccination interval of dogs and cats based upon the particular anti-rabies vaccine being administered to the animal.

In an attempt to make the content more understandable and to have a better flow when reading, certain Sections, Subsections and Paragraphs, etc., were moved from their current location in Part II to a new location in Part II. To assist in understanding where an existing subject is proposed to be moved, the following chart is provided:

Part II	
Existing Text Location	Proposed New Text Location
105.A – 105.A.4.a.xvi	105.D
105.A.5 – 105.A.5.a	109
105.B	105.E
107.A	105.A
107.B	105.B
109.A	105.C
113	107
111	113

The proposed amendments shall be made by effecting substantive changes as outlined below.

Title 51

PUBLIC HEALTH—SANITARY CODE

Part II. The Control of Diseases

Chapter 1. Disease Reporting Requirements

**§105. Reportable Diseases and Conditions
[formerly paragraph 2:003]**

A. It is hereby made the duty of every physician practicing medicine in the state of Louisiana to report to the state health officer, according to the requirements of this Section and utilizing the appropriate method(s) of reporting required under Subsection E of this Section, any case or suspected case of reportable disease or condition which he or she is attending, or has examined, or for which such physician has prescribed. The report shall be made promptly

at the time the physician first visits, examines or prescribes for the patient, and such report shall state the name, age, sex, race, usual residence, place where the patient is to be found, the nature of the disease or condition and the date of onset.

B. Any physician, whether Louisiana resident or non-resident, engaged in the practice of medicine at any federal installation or on any vessel, train or other common carrier, which enters any port, station or place in the state of Louisiana, is required to report as specified in Subsection A of this Section.

C. It shall be the duty of every osteopath, coroner, medical examiner, dentist, homeopath, infection control practitioner, laboratory director, medical records director, nurse, nurse midwife, nurse practitioner, pharmacist, physician assistant, podiatrist, poison control center, social worker, veterinarian, and any other health care professional to report a positive laboratory result or a confirmed or suspected case of any reportable disease or condition as required by this Section utilizing the appropriate method(s) of reporting required under Subsection E of this Section in which he or she has examined or evaluated, or for which he or she is attending or has knowledge. In the absence of a health care professional responsible for reporting as stated in the prior sentence (or a physician as referenced in Subsections A and B of this Section), it shall be the duty of the director, chief administrative officer, or other person in charge of any facility, program, or other entity that requires or conducts testing for reportable diseases or conditions, to report a positive laboratory result or a confirmed or suspected case of any reportable disease or condition as required by this Section utilizing the appropriate method(s) of reporting required under Subsection E of this Section.

D. The following diseases or conditions are hereby declared reportable with reporting requirements by class.

1. Class A Diseases or Conditions which Shall Require Reporting within 24 Hours

a. Class A diseases or conditions include diseases or conditions of major public health concern because of the severity of the disease or condition and the potential for epidemic spread. Class A diseases or conditions shall be reported to the Office of Public Health by telephone (or in another electronic format acceptable to the Office of Public Health) immediately upon recognition that a case, a suspected case, or a positive laboratory result is known. In addition, all cases of rare or exotic communicable diseases, unexplained death, unusual clusters of disease and all outbreaks shall be reported. Any class A disease or condition, rare or exotic communicable disease, unexplained death, or unusual cluster of disease and any disease outbreak, shall be reported to the Office of Public Health as soon as possible but no later than 24 hours from recognition that a case, a suspected case, a positive laboratory result, an unexplained death, an unusual cluster of disease, or a disease outbreak is known. The following diseases or conditions shall be classified as class A for reporting requirements:

- i. acute flaccid paralysis;
- ii. anthrax;
- iii. avian or novel strain influenza A (initial detection);
- iv. botulism;
- v. brucellosis;
- vi. cholera;

- vii. *Clostridium perfringens* food-borne infection;
- viii. diphtheria;
- ix. fish or shellfish poisoning (domoic acid poisoning, neurotoxic shellfish poisoning, ciguatera, paralytic shellfish poisoning, scombroid);
- x. food-borne infection;
- xi. *Haemophilus influenzae* (invasive infection);
- xii. influenza-associated mortality;
- xiii. measles (rubeola, imported or indigenous);
- xiv. *Neisseria meningitidis* (invasive infection);
- xv. outbreaks of any infectious diseases;
- xvi. pertussis;
- xvii. plague (*Yersinia pestis*);
- xviii. poliomyelitis (paralytic and non-paralytic);
- xix. Q fever (*Coxiella burnetii*);
- xx. rabies (animal and human);
- xxi. ricin poisoning;
- xxii. rubella (congenital syndrome);
- xxiii. rubella (German measles);
- xxiv. severe acute respiratory syndrome-associated coronavirus (SARS-CoV);
- xxv. *Staphylococcus aureus*, vancomycin intermediate or resistant (VISA/VRSA);
- xxvi. staphylococcal enterotoxin B (SEB) pulmonary poisoning;
- xxvii. smallpox;
- xxviii. tularemia (*Francisella tularensis*);
- xxix. viral hemorrhagic fever (Ebola, Lassa, Marburg, Crimean Congo, etc.); and
- xxx. yellow fever.

2. Class B Diseases or Conditions which Shall Require Reporting within One Business Day

a. Class B diseases or conditions include diseases or conditions of public health concern needing timely response because of potential for epidemic spread. The following class B diseases or conditions shall be reported to the Office of Public Health by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known:

- i. amoeba (free living) infection (including *Acanthamoeba*, *Naegleria*, *Balamuthia* and others);
- ii. anaplasmosis;
- iii. arthropod-borne viral infections (including West Nile, Dengue, St. Louis, California, Eastern Equine, Western Equine, Chikungunya, Usutu, and others);
- iv. aseptic meningitis;
- v. babesiosis;
- vi. Chagas disease;
- vii. chancroid;
- viii. *Escherichia coli*, Shiga-toxin producing (STEC), including *E. coli* O157:H7;
- ix. granuloma inguinale;
- x. hantavirus (infection or pulmonary syndrome);
- xi. hemolytic-uremic syndrome;
- xii. hepatitis A (acute illness);
- xiii. hepatitis B (acute illness and carriage in pregnancy);
- xiv. hepatitis B (perinatal infection);
- xv. hepatitis E;
- xvi. herpes (neonatal);
- xvii. human immunodeficiency virus [(HIV), infection in pregnancy]²;

- xviii. human immunodeficiency virus [(HIV), perinatal exposure]²;
- xix. legionellosis;
- xx. malaria;
- xxi. mumps;
- xxii. salmonellosis;
- xxiii. shigellosis;
- xxiv. syphilis¹;
- xxv. tetanus;
- xxvi. tuberculosis³ due to *Mycobacterium tuberculosis*, *bovis* or *africanum*; and
- xxvii. typhoid fever.

3. Class C Diseases or Conditions which Shall Require Reporting within Five Business Days

a. Class C diseases or conditions shall include diseases or conditions of significant public health concern. The following class C diseases or conditions shall be reported to the Office of Public Health within five business days after the existence of a case, suspected case, or a positive laboratory result is known:

- i. acquired immune deficiency syndrome (AIDS)²;
- ii. *Anaplasma phagocytophilum*;
- iii. blastomycosis;
- iv. campylobacteriosis;
- v. chlamydial infection¹;
- vi. coccidioidomycosis;
- vii. cryptococcosis (*Cryptococcus neoformans* and *C. gattii*);
- viii. cryptosporidiosis;
- ix. cyclosporiasis;
- x. ehrlichiosis (human granulocytic, human monocytic, *Ehrlichia chaffeensis* and *ewingii*);
- xi. *Enterococcus*, vancomycin resistant [(VRE), invasive disease];
- xii. giardiasis;
- xiii. glanders (*Burkholderia mallei*);
- xiv. gonorrhea¹ (genital, oral, ophthalmic, pelvic inflammatory disease, rectal);
- xv. Hansen's disease (leprosy);
- xvi. hepatitis C (acute illness);
- xvii. histoplasmosis;
- xviii. human immunodeficiency virus [(HIV) infection, other than as in class B]²;
- xix. human T lymphocyte virus (HTLV I and II) infection;
- xx. leptospirosis;
- xxi. listeriosis;
- xxii. Lyme disease;
- xxiii. lymphogranuloma venereum¹;
- xxiv. melioidosis (*Burkholderia pseudomallei*);
- xxv. meningitis, eosinophilic (including those due to *Angiostrongylus* infection);
- xxvi. Nipah virus infection;
- xxvii. non-gonococcal urethritis;
- xxviii. ophthalmia neonatorum;
- xxix. psittacosis;
- xxx. spotted fever rickettsioses [*Rickettsia* species including Rocky Mountain spotted fever (RMSF)];
- xxxi. staphylococcal toxic shock syndrome;
- xxxii. *Staphylococcus aureus*, methicillin/oxacillin-resistant [(MRSA), invasive infection];

- xxxiii. streptococcal disease, group A (invasive disease);
- xxxiv. streptococcal disease, group B (invasive disease);
- xxxv. streptococcal toxic shock syndrome;
- xxxvi. *Streptococcus pneumoniae* invasive disease;
- xxxvii. transmissible spongiform encephalopathies (Creutzfeldt-Jakob disease and variants);
- xxxviii. trichinosis;
- xxxix. varicella (chickenpox);
- xl. *Vibrio* infections (other than cholera); and
- xli. yersiniosis.

4. Class D Special Reportable Diseases or Conditions Shall Require Reporting within Five Business Days

a. Class D diseases or conditions shall include diseases or conditions of significant public health concern. The following class D diseases or conditions shall be reported to the Office of Public Health within five business days after the existence of a case, suspected case, or a positive laboratory result is known:

- i. cancer;
- ii. carbon monoxide exposure and/or poisoning;
- iii. complications of abortion;
- iv. congenital hypothyroidism⁴;
- v. galactosemia;
- vi. heavy metal (arsenic, cadmium, mercury) exposure and/or poisoning (all ages)⁵;
- vii. hemophilia;
- viii. lead exposure and/or poisoning (all ages);
- ix. pesticide-related illness or injury (all ages);
- x. phenylketonuria⁴;
- xi. pneumoconiosis (asbestosis, berylliosis, silicosis, byssinosis, etc.);
- xii. radiation exposure, over normal limits;
- xiii. Reye's syndrome;
- xiv. severe traumatic head injury;
- xv. severe undernutrition (severe anemia, failure to thrive);
- xvi. sickle-cell disease (newborns);
- xvii. spinal cord injury; and
- xviii. sudden infant death syndrome (SIDS).

E Case reports not requiring special reporting instructions (see below) can be reported by mail or facsimile [(504) 568-8290 (fax)] on confidential disease report forms, or by phone [call (800) 256-2748 for forms and instructions] or in an electronic format acceptable to the Office of Public Health. When selecting a method of notification, the person or entity submitting a report shall be respectful of the time limitations for the report to be received by the Office of Public Health in accordance with the particular time limitations specified under Classes A-D above.

1. ¹Report on STD-43 Form. Report cases of syphilis with active lesions by telephone, within one business day, to (504) 568-7474.

2. ²Report to the Louisiana HIV/AIDS Program. Visit www.hiv.dhh.louisiana.gov or call (504) 568-7474 for regional contact information.

3. ³Report on CDC72.5 (f.5.2431) card.

4. ⁴Report to the Louisiana Genetic Diseases Program and Louisiana Childhood Lead Poisoning Prevention Programs, www.genetics.dhh.louisiana.gov, or facsimile

[(504) 568-8253 (fax)], or call (504) 568-8254 or (800) 242-3112.

5. ⁵Report to the Section of Environmental Epidemiology and Toxicology, www.seet.dhh.louisiana.gov, or call (504) 568-8159 or (888) 293-7020.

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2) and R.S. 40:5(2)(10)(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1212 (June 2002), amended LR 32:1050 (June 2006), LR 34:2173 (October 2008), repromulgated LR 34:2582 (December 2008), LR 36:1014 (May 2010), repromulgated LR 36:1253 (June 2010), amended LR 39:1053 (April 2013), amended LR 41:

§107. Laboratory and Healthcare Facility Reporting Requirements

A. The director of every laboratory and other applicable healthcare facility whether public, private, hospital or other, within or out of the state shall report to the state health officer the results of all tests that are in any way clinically relevant, suggestive or indicative of an individual having active disease, past or present exposure to, past or present contact with and/or past or present association with any of the disease/conditions listed in LAC 51 (Public Health—Sanitary Code), Part II, Chapter 1, §105. The results of the tests to be reported to the state health officer do not have to be conducted for diagnostic reasons, nor do the results have to be diagnostic or confirmatory. The report shall be received in a timely manner consistent with the requirements of the diseases/conditions class described in §105 and shall state the name, date of birth, sex, race, usual residence, specimen identification code/ID and test results of the tested individual as well as the name of the physician or person submitting the specimen. Contact information for the laboratory performing the test(s) shall be provided. Laboratories shall not defer their public health reporting responsibilities to any other authorities within the institutions they serve. In addition, laboratories performing tests on specimens received from other laboratories shall report to the state health officer all results as prescribed above plus the contact information for the facility/laboratory where the specimen originated. Moreover, no considerations, evaluations or concerns, regarding any test technology or test result by institutions and/or organizations whether federal, state or otherwise (e.g., FDA, CMS-CLIA, etc.) which may be overseeing, approving, evaluating or licensing laboratory testing, shall represent an *a priori* rationale for withholding laboratory reports from the state health officer.

B. All laboratory facilities shall, in addition to reporting tests indicative of conditions found in §105, report positive or suggestive results for additional conditions of public health interest. The following findings shall be reported as detected by laboratory facilities:

- 1. adenoviruses;
- 2. coronaviruses;
- 3. enteroviruses;
- 4. hepatitis B (carriage, other than in pregnancy);
- 5. hepatitis C (past or present infection);
- 6. human metapneumovirus;
- 7. parainfluenza viruses;
- 8. respiratory syncytial virus; and
- 9. rhinoviruses.

C. A reference culture is required to be sent to the Office of Public Health laboratory for the following microorganisms within five business days of the final identification of the microorganism:

1. *Bacillus anthracis* (confirmed or suspected);
2. *Bordetella pertussis*;
3. *Brucella* spp.;
4. *Burkholderia mallei*;
5. *Burkholderia pseudomallei*;
6. *Campylobacter* spp.;
7. *Corynebacterium diphtheriae*;
8. *E. coli* O157:H7 or *E. coli* Shiga toxin producing;
9. *Francisella* spp.;
10. *Listeria* spp.;
11. *Mycobacterium tuberculosis*, *bovis* or *africanum*;
12. *Plesiomonas* spp.;
13. *Salmonella* spp.;
14. *Shigella* spp.;
15. *Vibrio* spp.;
16. *Yersinia enterocolitica*; and
17. *Yersinia pestis*.

D. A reference culture is required to be sent to the Office of Public Health laboratory for the following microorganisms if the original culture was from a sterile site (e.g., blood, spinal fluid, other internal fluid, tissue, etc.). Such reference culture shall be sent to the Office of Public Health laboratory within five business days of the final identification of the microorganism:

1. *Haemophilus influenzae* type b or untyped;
2. *Neisseria meningitidis*; and
3. *Streptococcus pneumoniae*.

E. Laboratory reports shall not be construed by the Office of Public Health as diagnosis. In the case of private patients, follow-up of laboratory reports shall be through the physician(s) submitting the specimen(s).

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2) and R.S. 40:5(2)(10)(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1213 (June 2002), amended LR 36:1015 (May 2010), LR 41:

§109. Reports by Emergency Departments

A. Syndromic Surveillance: Reportable Conditions seen at Emergency Departments of Acute Care Hospitals which Shall Require Reporting Electronically within One Business Day of the Visit

1. Emergency department reporting shall include all conditions seen at emergency departments of acute care hospitals. The text content of the chief complaint for the visit or an international classification of disease code shall be reported to the Office of Public Health within one business day of the visit by electronic means as specified by the Office of Public Health.

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2) and R.S. 40:5(2)(10)(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1213 (June 2002), amended LR 32:1051 (June 2006), LR 36:1015 (May 2010), LR 41:

§111. Reports by Hospitals

A. It shall be the duty of all hospitals producing antibiograms detailing the antibiotic sensitivities and

resistances of microorganisms in their facility to provide a report annually of antibiogram results to the state health officer.

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2) and R.S. 40:5(2)(10)(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1213 (June 2002), amended LR 36:1015 (May 2010), LR 41:

§113. Reports Required of Parents, Schools and Day Care Centers

A. It shall be the duty of every parent, guardian, householder, attendant or other person in charge, principal of a public or private school, operator of a day care center or residential facility (public or private) to report a case of reportable disease in his household or school to the state health officer [as required by Subsection 105.C of this Chapter utilizing the appropriate method(s) of reporting required under Subsection 105.E of this Chapter], when he or she knows or reasonably believes that the disease is one which legally must be reported, except when he or she knows or reasonably believes that a physician, presumed to have already reported the case, is in attendance.

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2) and R.S. 40:5(2)(10)(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1214 (June 2002), amended LR 32:1052 (June 2006), LR 39:1054 (April 2013), LR 41:

Part III. The Control of Rabies and Other Zoonotic Diseases

Chapter 1. Anti-Rabies Vaccination Requirements for Dogs and Cats

§103. Mandatory Vaccinations of Dogs, Cats, and Ferrets

[formerly paragraph 3:002]

A. No person shall own, keep or have in his custody a dog, cat, or ferret over three months of age that has not been vaccinated against rabies by a licensed veterinarian. Every owner of a dog, cat, or ferret shall cause said animal to be vaccinated initially with a series of two vaccinations, the first to be administered at three months of age, the second to be administered one year after the initial vaccination. Dogs, cats, or ferrets initially vaccinated later than three months of age shall also be administered a series of two vaccines, the second vaccine to be given one year after the initial vaccination. Thereafter, the interval between revaccinations shall conform to the *Compendium of Animal Rabies Prevention and Control*, 2011 Edition, Part III: Rabies Vaccines Licensed and Marketed in the U.S., which is published by the National Association of State Public Health Veterinarians, Inc. Vaccine licensing and labeling, including duration of immunity, is authorized by the Center for Veterinary Medicine at the Food and Drug Administration (FDA) and those decisions are based on testing conducted by the vaccine manufacturers. The results of testing are presented to the FDA during the registration process.

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(2)(a), R.S. 40:5(1)(2)(17) and R.S. 40:1277.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1223 (June 2002), amended LR 33:650 (April 2007), LR 41:

Part XVII. Public Buildings, Schools, and Other Institutions

Chapter 5. Health Requirements for Schools

§501. Employee Health and Student Health [formerly paragraph 17:028]

A. [Formerly paragraph 17:028] The requirements of Part I, §117 and Part II, §§113 and 503 shall be met.

B.1. - B.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(2)(10) and R.S. 40:5 (1)(2)(10)(17).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1392 (June 2002), repromulgated LR 29:1099 (July 2003), amended LR 41:

Part XXI. Day Care Centers and Residential Facilities

Chapter 1. General Requirements

§105. General

[formerly paragraph 21:002-1]

A. - B. ...

C. [Formerly paragraph 21:003] All of the above facilities shall comply with appropriate Parts of this Code as stated below.

1. [Formerly paragraph 21:003-1] Employee, patient, and client health shall meet the requirements of Part I, §117 and Part II, §§113, 503, and 505 of this Code.

C.2. - J.2 ...

AUTHORITY NOTE: Promulgated in accordance with the provisions of R.S. 40:4(A)(10) and R.S. 40:5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1399 (June 2002), amended LR 37:2728 (September 2011), amended LR 38:2926 (November 2012), repromulgated LR 38:3233 (December 2012), amended LR 41:

Family Impact Statement

- 1. The effect on the stability of the family. None
- 2. The effect on the authority and rights of parents regarding the education and supervision of their children. None
- 3. The effect on the functioning of the family. None
- 4. The effect on the family earnings and family budget. None
- 5. The effect on the behavior and personal responsibility of children. None
- 6. The ability of the family or local government to perform the function as contained in the Proposed Rule. None

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

It is anticipated that the proposed Rule will not have a significant adverse effect on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental, and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed rule to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of the proposed rulemaking has been considered. There is no anticipated impact on the staffing level requirements or qualifications, cost, or ability

of providers of services for individuals with developmental disabilities to provide such services.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Such comments should be submitted no later than October 26, 2015, at 4:30 p.m. to Theresa Sokol, Infectious Disease Surveillance, Infectious Disease Epidemiology Section, Office of Public Health, 1450 Poydras Street, Suite 2155, New Orleans, LA 70112. Comments may be faxed to (504) 568-8290.

Public Hearing

A public hearing is scheduled for October 26, 2015, at 9:30 a.m. in room 173 at the DHH Bienville Building, 628 North Fourth Street, Baton Rouge, LA 70802. Please call (504) 568-8313 in advance to confirm the time and place of the public hearing, as the public hearing will be cancelled if the requisite number of comments is not received by October 10, 2015.

Jimmy Guidry, M.D.
State Health Officer
and
Kathy Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Updating the Disease Reporting Requirements

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The propose rule amends Louisiana Sanitary Code (LAC Title 51) Part II – The Control of Diseases, Sections 105-113, Part III – The Control of Rabies and Other Zoonotic Diseases, Section 103, Part XVII – Public Buildings, Schools, and Other Institutions, Section 501, and Part XXI – Day Care Centers and Residential Facilities, Section 105. Amendments update current disease reporting requirements of the Department of Health and Hospitals (DHH), Office of Public Health (OPH) based on recommendations of the Council of State and Territorial Epidemiologists (CSTE) and the federal Centers for Disease Control and Prevention (CDC).

The main purpose of amending the sanitary code under this proposed rule is to add various rare infectious diseases to the list of reportable diseases and conditions that are reported to the state health officer within DHH/OPH. The proposed rule updates the disease reporting criteria in Part II, Part XVII and Part XXI of the sanitary code that makes reporting more consistent with recommendations of the CDC. Also, the proposed rule updates the rabies vaccination guidelines in Part III to meet current national recommendations.

The proposed rule changes will result in an estimated cost to DHH-OPH of \$2,036 to publish the notice of intent and the final rule in the *Louisiana Register*. This is a one-time cost that is routinely included in the agency’s budget.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no estimated effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule directly affects hospitals, clinics, laboratories, and other facilities, which report infectious diseases. Due to the addition of diseases to the list of

reportable conditions, there may be a slight increase in workload for health care providers and/or facilities. Some diseases will now only be reportable by laboratories, rather than all healthcare facilities, reducing some of the overall burden of reporting.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment.

J. T. Lane
Assistant Secretary
1509#091

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of Public Health

Tanning (LAC 49:I.Chapter 13)

Under the authority of R.S. 40:4 and 40:5, and in accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the state health officer, acting through the Department of Health and Hospitals, Office of Public Health (DHH, OPH), intends to recodify the Chapter 13 regulations originally promulgated in the March 20, 1992 edition of the *Louisiana Register* in accordance with Act 587 of 1990 and to amend the newly recodified Sections 1301-1349 of Part I of Title 49 of the *Louisiana Administrative Code* to reflect administrative changes and to comply with the requirements of Act 193 of 2014. These changes are required to enforce the new ban on minors' use of tanning equipment enacted during the recent Regular Session of the Louisiana Legislature.

Title 49

PUBLIC HEALTH—FOOD AND DRUGS

Part I. Food, Drugs, and Cosmetics

Chapter 13. Tanning Facility Regulations

§1301. Purpose and Scope

[formerly 49:8.0000]

A. These regulations provide for the registration, certification and regulation of facilities and equipment which employ ultraviolet and other lamps for the purpose of tanning the skin of the living human body through the application of ultraviolet radiation.

B. The current statutory provisions in R.S. 40:2701 through 2719, as enacted by Act No. 587 of 1990, indicates that the owner or proprietor of each tanning parlor facility must apply for a certificate of registration as well as a separate permit from the Department of Health and Hospitals. In order to implement Act No. 587 of 1990 efficiently, and to accomplish the desired regulatory results in the best interest of the public health, the department will require a single application to register and obtain a permit for each tanning parlor facility in the state. Upon completion of processing, which includes inspection of each such facility by a department employee, only a single certificate of registration and permit will be issued. The combined instrument will expire at midnight on the date specified on the face of the document, and it must be renewed annually, as further specified in these regulations.

C. Nothing in these regulations shall be interpreted as limiting the intentional exposure of patients to ultraviolet

radiation for the purpose of treatment or therapy other than skin tanning, provided such treatment or therapy is supervised by a licensed practitioner of the healing arts in the lawful practice of their profession, in accordance with the requirements of their professional licensing board to prescribe and supervise such treatment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1303. Authority

[formerly 49:8.0010]

A. These regulations are promulgated under authority of the Tanning Facility Regulation Act comprising R.S. 40:2701 through 2719 (Act No. 587 of 1990), as amended by Act No. 193 of 2014.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1305. Definitions

[formerly 49:8.0020]

Act—Tanning Facility Regulation Act, unless the text clearly indicates a different meaning. All definitions and interpretations of terms given in the Act shall be applicable also to such terms when used in these regulations.

Authorized Agent—an employee of the department designated by the state health officer to enforce the provisions of the Act. The responsibility for implementing the provisions of the Act has been assigned to the Food and Drug Unit of the Office of Public Health of the Department of Health and Hospitals.

Consumer—any individual who is provided access to a tanning facility which is required to be registered pursuant to provisions of these regulations.

Department—the Department of Health and Hospitals.

Formal Training—a course of instruction approved by the department and presented under formal classroom conditions by a qualified expert possessing adequate knowledge and experience to offer a curriculum, associated training, and certification testing pertaining to and associated with the correct use of tanning equipment.

Individual—any human being.

Operator—any individual designated by the registrant to operate or to assist and instruct the consumer in the operation and use of the tanning facility or tanning equipment.

Persons—any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency, political subdivision or agency thereof, and any legal successor, representative, agent, or agency of these entities.

Phototherapy Device—a piece of equipment that emits ultraviolet radiation and is used by a licensed health care professional in the treatment of disease.

Registrant—any person who has filed for and received a certificate of registration-permit issued by the department as required by provisions of these regulations.

Secretary—the secretary of the Department of Health and Hospitals.

State Health Officer—the employee of the department who is the chief health care official of the state as provided for in R.S. 40:2.

Tanning Equipment—ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the irradiation of any part of the living human body with ultraviolet radiation.

Tanning Facility—any location, place, area, structure, or business which provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same persons, but at separate locations, shall constitute separate tanning facilities.

Ultraviolet Radiation—electromagnetic radiation with wavelengths in air between 200 nanometers and 400 nanometers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:209 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1307. Exemptions

[formerly 49:8.0030]

A. As provided in R.S. 40:2704, any person is exempt from the provisions of these regulations to the extent that such person:

1. uses equipment which emits ultraviolet radiation incidental to its normal operation;
2. does not use the equipment described in Paragraph 1 of this Subsection to deliberately expose parts of the living human body to ultraviolet radiation for the purpose of tanning or other treatment.

B. Any physician licensed by the Louisiana State Board of Medical Examiners is exempt from the provisions of these regulations and is authorized to use a phototherapy device or other medical diagnostic and the therapeutic equipment which emits ultraviolet radiation.

C. Any individual is exempt from the provisions of these regulations to the extent that such individual owns tanning equipment exclusively for non-commercial use.

D. Tanning equipment while in transit or storage incidental thereto is exempt from the provisions of these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:209 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1309. Certificate of Registration-Permit

[formerly 49:8.0040]

A. Each person owning or operating a tanning facility or facilities within the state of Louisiana shall apply for a certificate of registration-permit for each such facility or facilities no later than April 1, 1992.

B. The application for a certificate of registration-permit required above shall be made on forms provided by the department and shall contain all the information required by such forms and any accompanying instructions.

C. The application for certificate of registration-permit shall include the information required in R.S. 40:2705(D).

D. A fee of \$150 shall accompany each initial application for a certificate of registration-permit

E. Each tanning facility operating within the state for which an application for registration-permit and fee has been received by the department shall be issued a temporary registration-permit until such time that an inspection of the tanning facility and equipment can be made and it is determined that a permanent registration-permit to operate can be issued.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:209 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1311. Issuance of Certificate of Registration-Permit [formerly 49:8.0050]

A. A certificate of registration-permit shall be issued upon receipt of an application provided that no certificate of registration-permit be issued until inspection has been made of the tanning facility and it has been found to be operating in compliance with the provisions of the Act and these regulations.

B. The certificate of registration-permit shall be displayed in an open public area of the tanning facility.

C. An annual certificate of registration-permit shall be issued upon receipt of an application of forms provided by the department for this purpose and required renewal fees.

D. A certificate of registration-permit shall be issued only to the person or persons responsible for the operations of the tanning facility and shall not be transferable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1313. Renewal of Registration-Permit [formerly 49:8.0060]

A. The registrant shall file applications for renewal of certificate of registration-permit on forms provided by the department. The application shall be sent to the mailing address of the principal registrant listed on the last application for registration-permit submitted.

B. An annual renewal fee of \$110 shall accompany each annual renewal. Make check or money order payable to the Food and Drug Unit/Department of Health and Hospitals.

C. Provided that a registrant files an application with the department in proper form not less than thirty days prior to the expiration date stated on the certificate of registration-permit, the certificate shall not expire pending final action on the application by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:209 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1315. Report of Changes
[formerly 49:8.0070]

A. The registrant shall notify the department in writing before making any change which would render the information contained in the application for certificate of registration-permit inaccurate. Notification of changes shall include information required by R.S. 40:2705(D)1, 2, 3, 4, 6.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1317. Transfer of Certificate of Registration-Permit
[formerly 49:8.0080]

A. No certificate of registration-permit may be transferred from one person to another or from one tanning facility to another tanning facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1319. Prohibited Acts; Advertisement
[formerly 49:8.0090]

A. A tanning facility may not claim or distribute promotional materials that claim use of a tanning device is safe or free from risk.

B. No person shall state or imply that any activity under such certificate of registration-permit has been approved by the department.

C. No person or tanning facility may claim health benefits from the use of a tanning device unless such claims have been approved in advance by the state health officer.

D. No tanning facility may allow any person under eighteen years of age to use any tanning equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:210 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1321. Denial, Suspension, or Revocation of a Certificate of Registration-Permit
[formerly 49:8.0100]

A. The department may deny, suspend, or revoke a certificate of registration-permit applied for or issued pursuant to these regulations:

1. for any material false statement in the application for certificate of registration-permit or in any statement of fact required by provisions of this Chapter;

2. because of conditions revealed by the application or any report, record, inspection or other means which would warrant the department to refuse to grant a certificate of registration-permit on an original application;

3. for operation of the tanning facility in a manner that causes or threatens to cause hazard to the public health or safety;

4. for failure to allow authorized representatives of the department to enter the tanning facility during normal business hours for the purpose of determining compliance with the provisions of these regulations, the Tanning Facility Regulation Act, conditions of the certificate of registration-permit, or an order of the department;

5. for violation of or failure to observe any of the terms and conditions of the certificate of registration, the provisions of this Chapter, or an order of the department;

6. failure to pay a certificate of registration-permit fee or annual renewal fee;

7. the registrant obtained or attempted to obtain a certificate of registration-permit by fraud or deception;

8. the operation of a tanning facility without a valid certificate of registration-permit or the continued operation after a certificate has been revoked or suspended, shall constitute a violation of these regulations. Each day of noncompliance shall constitute a separate violation.

B. Except in cases of willful disregard for the public health and safety, prior to the institution of proceedings for suspension or revocation of a certificate of registrant-permit, the agency shall:

1. call to the attention of the registrant in writing, the facts or conduct which may warrant such actions;

2. provide reasonable and sufficient opportunity for the registrant to demonstrate or achieve compliance with all lawful requirements.

C. The department may deny a certificate of registration-permit or suspend or revoke a certificate of registration-permit after issuance only in accordance with the Administrative Procedure Act.

D. The department may terminate a certificate of registration-permit upon receipt of a written request for termination from the registrant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:210 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1323. Compliance with Federal and State Law
[formerly 49:8.0110]

A. Tanning devices used by a tanning facility shall comply with 21 *Code of Federal Regulations* (CFR) part 1040.20, sunlamp products and ultraviolet lamps intended for use in sunlamp products.

B. Except as otherwise ordered or approved by the department, each tanning facility shall be constructed, operated, and maintained in accordance with the requirements of R.S. 40:2710 through 40:2714.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1325. Warning Signs Required
[formerly 49:8.0120]

A. The registrant shall conspicuously post the warning sign described in Subsection B of this Section within three feet of each tanning station and in such a manner that the sign is clearly visible, not obstructed by any barrier, equipment or other object, and can be easily viewed by the consumer before energizing the tanning equipment.

B. The sign required by this Section shall be printed in upper and lower case letters which are at least one-half inch and one-quarter inch in height, respectively, and shall contain the following warnings:

Danger—Ultraviolet Radiation

- Follow instructions.
- Avoid overexposure. As with natural sunlight, repeated exposure to ultraviolet radiation can cause chronic sun damage characterized by premature aging of the skin, wrinkling, dryness, fragility and bruising of the skin, and skin cancer.
- Wear protective eyewear.

**Failure to Use Protective Eyewear May
Result in Severe Burns or Permanent
Injury to the Eyes.**

- Medications or cosmetics may increase your sensitivity to the ultraviolet radiation.
- Consult a physician before using sunlamp or tanning equipment if you are using medications or have a history of skin problems or believe that you are especially sensitive to sunlight. Pregnant women or women taking oral contraceptives who use this product may develop discolored skin.

**If You Do Not Tan in the Sun, You are Unlikely
to Tan from the Use of Ultraviolet Radiation
of Tanning Equipment.**

C. Each registrant shall place, at the entrance of the tanning facility, signage that states the following: “LOUISIANA LAW PROHIBITS PERSONS UNDER 18 YEARS OF AGE FROM USING ANY TANNING FACILITY EQUIPMENT THAT EMITS ULTRAVIOLET LIGHT FOR THE PURPOSE OF SKIN TANNING”; this sign shall be of dimensions of at least eight inches by ten inches.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:210 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1327. Tanning Equipment Standards
[formerly 49:8.0130]

A. Equipment used in tanning facilities shall conform to the standards set forth in R.S. 40:2711(A) through (D) as well as the following.

1. Tanning equipment booths or rooms shall be of rigid construction.
2. Wall surfaces within booths or rooms shall be easily cleanable and shall be kept clean at all times.
3. Ceilings, where provided, shall be easily cleanable and shall be kept clean.
4. Floors within tanning equipment booths or rooms shall be constructed of readily cleanable materials including, but not limited to, vinyl tile, sheet vinyl, quarry tile, glazed brick, short pile carpet or rugs, or other suitable material.
5. Floors shall be kept clean and in good repair at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1329. Requirements for Stand-Up Booths
[formerly 49:8.0140]

A. Tanning booths designed for stand-up use shall also comply with the requirements of R.S. 40:2712.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

**§1331. Potable Water Supply; Sanitary Facilities;
Sewage and Waste Disposal**
[formerly 49:8.0150]

A. Each tanning facility shall provide an ample supply of potable hot and cold water, under pressure for drinking, cleansing, washing or other purposes. Such water supply shall not be cross connected to any other supply.

B. Each tanning facility shall provide toilet and hand washing facilities according to requirements of Part XIV, Table 411 of the state *Sanitary Code* and each toilet shall be furnished with toilet tissue. The facilities shall be maintained in a sanitary condition and kept in good repair at all times. Doors to toilet rooms shall be self-closing. Toilet rooms shall be well lighted and ventilated.

C. Sewage disposal shall be made in a sewage system or by other means approved by the State Health Officer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1333. Rubbish and Trash Disposal
[formerly 49:8.0160]

A. Rubbish, trash, and other debris including used or burned out tanning lamps shall be so conveyed, stored and disposed of as to minimize the development of odor and to prevent harborage of vermin.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1335. Operational Requirements
[formerly 49:8.0170]

A. Each tanning facility must be operated under the requirements set forth by R.S. 40:2713.

B. Each tanning facility shall establish and adhere to effective procedures for cleaning and sanitizing each tanning bed or booth as well as protective eyewear before and after use of such equipment by each consumer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:210 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1337. Information Provided to Consumers, Warnings
[formerly 49:8.0180]

A. Each tanning facility operator shall provide each consumer, prior to initial exposure, a written warning statement as required by R.S. 40:2714(A). Such warning statements shall be signed by each consumer and maintained permanently on file at the tanning facility. A copy of the signed warning statement shall be given to each consumer. Copies of such warning statement shall be available for review during inspections by duly authorized agents of the state health officer. The written warning statement shall warn that:

1. failure to use eye protection provided to the customer by the tanning facility may result in damage to the eyes;
2. overexposure to ultraviolet light causes burns;
3. repeated exposure may result in premature aging of the skin and skin cancer;
4. abnormal skin sensitivity or burning may be caused by reactions of ultraviolet light to certain:
 - a. foods;
 - b. cosmetic;
 - c. medications, including tranquilizers, diuretics, antibiotic, high blood pressure medicines, and oral contraceptives;
5. any person taking a prescription or over-the-counter drug should consult a physician before using a tanning device;
6. a person should not sunbathe before or after exposure to ultraviolet radiation from sunlamps.

B. Consumer warning statements acknowledged by each consumer by signature prior to initial exposure shall be maintained on file within the tanning facility and shall be made readily available for review by authorized agents of the Department of Health and Hospitals, Office of Public Health.

C. The registrant shall maintain for six years a record of each consumer's total number of tanning visits, dates, and duration of tanning exposures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended LR 19:210 (February 1993), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1339. Reports to the Department
[formerly 49:8.0190]

A. The registrant shall submit to the department a written report of actual or alleged injury from the use of registered tanning equipment within five working days after occurrence or notice thereof as required by R.S. 40:2714(D). The report shall include:

1. the name of the affected individual;
2. the name, location, and number of the certificate of registration-permit for the tanning facility and identification of the specific tanning equipment involved, including the name, model number, date of manufacture and type of lamp(s);
3. the nature of the actual or alleged injury, as well as the complete name, address and telephone number of any doctor visited for medical attention;

5. any other information relevant to the actual or alleged injury, including the date and duration of exposure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1341. Replacement of Ultraviolet Lamps, Bulbs, Filters
[formerly 49:8.0210]

A. Defective and burned out lamps, bulbs, or filters shall be replaced in accordance with R.S. 40:2714(F) and (G).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1343. Tanning Equipment Operator Training
[formerly 49:8.0220]

A. The registrant shall certify that all tanning equipment operators are adequately trained in at least the following:

1. the requirements of these regulations;
2. procedures for correct operation of the tanning facility and tanning equipment;
3. recognition of injury or overexposure to ultraviolet radiation;
4. the tanning equipment manufacturer's procedures for operation and maintenance of the tanning equipment;
5. the determination of skin type of consumers and appropriate determination of duration of exposure to registered tanning equipment;
6. emergency procedure to be followed in case of injury.

B. The registrant shall limit the operation of tanning equipment to persons who have successfully completed formal training courses which cover the provisions of Paragraph A.1 of this Subsection, and have been approved by the department.

C. The registrant shall maintain a record of operator training required in Paragraph A.2 of this Subsection for inspection by authorized representatives of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1345. Inspections by Department
[formerly 49:8.0230]

A. In order to effect the enforcement of these regulations, officers or employees duly authorized by the department or the state health officer, after making reasonable request, may enter any registered or unregistered tanning facility and inspect all tanning booths, rooms, tanning equipment, tanning devices, consumer records, and any other materials used in the tanning facility.

B. No tanning facility registrant, owner, or operator shall refuse this reasonable inspection request, without being subjected to provisions of §1321.A.4 of these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1347. Penalties; Criminal Penalty; Injunction
[formerly 49:8.0240]

A. Criminal penalties or injunctions may be imposed upon a tanning facility operator as provided by 40:2716 and 40:2717 of the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18:274 (March 1992), amended by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1349. Communications with the Department,
Department Address
[Formerly 49:8.0250]

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2701-2719.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Food and Drug Unit, LR 18: 274 (March 1992), repealed by the Department of Health and Hospitals, Office of Public Health, LR 41:

Family Impact Statement

1. The effect on the stability of the family. The goal of this Rule is to prevent disease and illnesses; therefore, a lower disease and illness rate of family members because of this Rule should help the family to remain stable.

2. The effect on the authority and rights of parents regarding the education and supervision of their children. No effect on the authority and rights of parents regarding the education and supervision of their children is anticipated as a result of this proposed rulemaking.

3. The effect on the functioning of the family. The goal of this Rule is to prevent disease and illnesses; therefore, a lower disease and illness rate of family members because of this Rule should help the family to function better than it may should a family member become ill if such Rule did not exist.

4. The effect on the family earnings and family budget. It is expected that family members would remain more healthy with the adoption of this rule than if such Rule did not exist; therefore, the family earnings and budget may be protected from additional costs should a family member become ill if such Rule did not exist.

5. The effect on the behavior and personal responsibility of children. No effect on the behavior and personal responsibility of children is anticipated as a result of this proposed rulemaking.

6. The ability of the family or local government to perform the function as contained in the proposed Rule. The family or local governments have no function to perform under this Rule; therefore, the family or local government's ability to perform the function under this Rule is a non-issue.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

It is anticipated that the proposed Rule will not have a significant adverse effect on small businesses as defined in

the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental, and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed rule to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of the proposed rulemaking has been considered. There is no anticipated impact on the staffing level requirements or qualifications, cost, or ability of providers of services for individuals with developmental disabilities to provide such services.

Public Comments

In addition, all interested persons are invited to submit written comments on the proposed Rule. Such comments must be received no later than Monday, October 26, 2015, at close of business or 4:30 pm, and should be addressed to Brian R. Warren, Food and Drug/Milk and Dairy Unit, Office of Public Health, Mail Bin #10, Box #14, P.O. Box 4489, Baton Rouge, LA 70821-4489, or faxed to (225) 342-7672. If comments are to be shipped or hand-delivered, please deliver to the Bienville Building, 628 N. 4th Street, Room 166, Baton Rouge, LA 70802.

Public Hearing

DHH-OPH will conduct a public hearing on October 26, 2015, beginning at 9:30 a.m. in room 173 of the Bienville Building located at 628 North Fourth Street, Baton Rouge, LA 70802. Persons attending the hearing may have their parking ticket validated when one parks in the 7-story Galvez Parking Garage which is located between N. 6th and N. 5th/North and Main Sts. (catercorner and across the street from the Bienville Building). All interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing.

Jimmy Guidry
State Health Officer
and
Kathy Klibert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Tanning

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule recodifies and amends Louisiana Administrative Code Title 49, Part I, Chapter 13 – Tanning Facility Regulations, which was originally promulgated in the March 20, 1992 edition of the *Louisiana Register* in accordance with Act 587 of 1990. Amendments to the newly recodified Sections 1301-1347 of Chapter 13 reflect administrative changes as well as requirements of Act 193 of 2014 that enforced a new ban on minors' use of tanning equipment.

The following are amendments to each section: (1) Section 1301 deletes Subsection D, a reference to the "Red Book" that is obsolete; (2) Section 1303 adds language reflecting changes made in Act 193 of 2014; (3) Section 1305 deletes the definition of "tutor," which is no longer relevant to the enforcement of this code; (4) Sections 1307 and 1309 changes the specified fee amounts, which were changed by Act 125 of

2000, and removes extraneous language; (5) Section 1315 inserts language banning minors from using UV tanning equipment in registered facilities in Louisiana; (6) Section 1321 inserts language regarding the new signage mandated by Act 193 of 2014; (7) Section 1327 corrects code references and grammatical errors; (8) Section 1329 replaces “light bulbs” with “tanning lamps”; (9) deletes Section 1337 in its entirety; (10) Section 1341 removes the “effective date” language as it pertains to operating training requirements to comply with Act 193 of 2014; and (11) deletes Section 1347 in its entirety, as the information is obsolete and other means of contacting the department are readily available.

The proposed changes will result in an estimated state cost of \$1,148 to publish the notice of intent and the final rule in the *Louisiana Register*. This is a one-time cost that is included in the agency’s budget.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule is not anticipated to have any impact on State revenue collections as it does not change existing licensing/inspection fees.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Act 193 of 2014 that banned minors from tanning has been effective since August 1, 2014. Any decrease in revenue to registered tanning entities was experienced in 2014. Therefore, the proposed rule is not anticipated to have any impact on registered entities that were previously allowing minors to tan in the state of Louisiana in future fiscal years.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Act 193 of 2014 that banned minors from tanning has been effective since August 1, 2014. Any potential decrease in employment at registered facilities as a result of decrease in business was experienced in 2014. Therefore, the proposed rule is not anticipated to have any impact on registered tanning entities in future fiscal years.

J.T. Lane
Assistant Secretary
1509#092

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Insurance
Office of the Commissioner**

**Regulation 32—Group Coordination of Benefits
(LAC 37:XIII.Chapter 3)**

The Department of Insurance, pursuant to the authority of the *Louisiana Insurance Code*, R.S. 22:1 et seq., and in accordance with the Administrative Procedure Act., R.S. 49:950 et seq., hereby gives notice of its intent to amend and promulgate Regulation 32—Group Coordination of Benefits. The purpose of the regulation is to establish a uniform order of benefit determinations.

The purpose for amending Regulation 32 is for the Department of Insurance to adopt the National Association of Insurance Commissioners’ Model regulation entitled “Coordination of Benefits Model Regulation”.

**Title 37
INSURANCE**

Part XIII. Regulations

Chapter 3. Regulation 32—Group Coordination of Benefits

§301. Purpose and Applicability

A. The purpose of this regulation is to:

1. establish a uniform order of benefit determination under which plans pay claims;
2. reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first; and
3. provide greater efficiency in the processing of claims when a person is covered under more than one plan.

B. This regulation applies to all plans which includes all accident and health products and health maintenance organization products that are issued on or after the effective date of this regulation, which is [insert date].

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§303. Definitions

A. As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise.

Allowable Expense—except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

a. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the *Internal Revenue Code* of 1986, the primary high-deductible health plan’s deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the *Internal Revenue Code* of 1986.

b. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

c. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

d. The following are examples of expenses that are not allowable expenses.

i. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement

or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

e. The definition of allowable expense may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

f. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

g. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

i. because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

ii. because the covered person has a lower benefit because the covered person did not use a preferred provider.

Birth day—refers only to month and day in a calendar year and does not include the year in which the individual is born.

Claim—a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. services (including supplies);

b. payment for all or a portion of the expenses incurred;

c. a combination of Subparagraphs a and b of this Paragraph; or

d. an indemnification.

Claim Determination Period or *Plan Year*—a period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each plan will pay or provide.

a. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination

period if that person's coverage starts or ends during the claim determination period.

b. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

Closed Panel Plan—a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or *COBRA*—coverage provided under a right of continuation pursuant to federal law.

Coordination of Benefits or *COB*—a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent—

a. the parent awarded custody of a child by a court decree; or

b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract—a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

High-Deductible Health Plan—the meaning given the term under section 223 of the *Internal Revenue Code* of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Hospital Indemnity Benefits—benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan—a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection. The definition of "plan" in the model COB provision in Appendix A of §321 of this Chapter is an example.

- a. Plan includes:
 - i. group and nongroup insurance contracts and subscriber contracts;
 - ii. uninsured arrangements of group or group-type coverage;
 - iii. group and nongroup coverage through closed panel plans;
 - iv. group-type contracts;
 - v. the medical care components of long-term care contracts, such as skilled nursing care;
 - vi. the medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;
 - vii. Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this Paragraph. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and
 - viii. group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
- b. Plan does not include:
 - i. hospital indemnity coverage benefits or other fixed indemnity coverage;
 - ii. accident only coverage;
 - iii. specified disease or specified accident coverage;
 - iv. limited benefit health coverage as defined in R.S. 22:47(2)(c);
 - v. school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;
 - vi. benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
 - vii. Medicare supplement policies;
 - viii. a state plan under Medicaid; or
 - ix. a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Policyholder or Subscriber—the primary insured named in a nongroup insurance policy.

Primary Plan—a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or
- b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Provider—a health care professional or health care facility.

Secondary Plan—a plan that is not a primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§305. Use of Model COB Contract Provision

A. Appendix A of §321 of this Chapter contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections B, C and D of this Section and to the provisions of §307 of this regulation.

B. Appendix B of §323 of this Chapter is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two or more plans will pay for or provide benefits.

C. The COB provision contained in Appendix A of §321 of this Chapter and the plain language explanation in Appendix B of §323 of this Chapter do not have to use the specific words and format shown in Appendix A of §321 of this Chapter or Appendix B of §323 of this Chapter. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

1. another plan exists and the covered person did not enroll in that plan;
2. a person is or could have been covered under another plan, except with respect to Part B of Medicare; or
3. a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are “always excess” or “always secondary” except in accordance with the rules permitted by this regulation and R.S. 22:1072.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of §309 of this regulation to determine the amount it should pay for the benefit.

G. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in this regulation and pursuant to R.S. 22:1072.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§307. Rules for Coordination of Benefits

A. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows.

1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

2. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

3. When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

4. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

5. Except as provided in Paragraph 2 of this Subsection, a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this Paragraph, state that the complying plan is primary.

6. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

B. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

C. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies:

1. Non-Dependent or Dependent

a. Subject to Subparagraph b of this Paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

b. If the person is a Medicare beneficiary, and, as a result of the provisions of title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. secondary to the plan covering the person as a dependent; and

ii. primary to the plan covering the person as other than a dependent (e.g. a retired employee).

c. Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

4. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

ii. if both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

i. if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

ii. if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph a of this Paragraph shall determine the order of benefits;

iii. if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph a of this Paragraph shall determine the order of benefits; or

iv. if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) the plan covering the custodial parent;

(b) the plan covering the custodial parent's spouse;

(c) the plan covering the non-custodial parent; and then

(d) the plan covering the non-custodial parent's spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph a or b of this Paragraph as if those individuals were parents of the child.

d. For a dependent child covered under spouse's plan

i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph 5 of this Subsection applies.

ii. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying

the birthday rule in Subparagraph a of this Paragraph to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-Off Employee

a. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

b. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph 1 of this Subsection can determine the order of benefits.

4. COBRA or State Continuation Coverage

a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph 1 of this Subsection can determine the order of benefits

5. Longer or Shorter Length of Coverage

a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

c. The start of a new plan does not include:

i. a change in the amount or scope of a plan's benefits;

ii. a change in the entity that pays, provides or administers the plan's benefits; or

iii. a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

d. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§309. Procedure to be followed by Secondary Plan to Calculate Benefits and Pay a Claim

A. In determining the amount to be paid by the secondary plan on a claim, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan coinsurance, copayments or deductible (benefit reserves) any amounts it would have credited to its coinsurance, copayments or deductible in the absence of other health care coverage. Such credit shall be utilized for the policyholder. As each claim is submitted, the secondary plan must:

1. determine its obligation, pursuant to its contract;

2. determine whether a benefit reserve has been recorded for the covered person; and

3. determine whether there are any unpaid allowable expenses during that claims determination period.

B. If there is a credit, the secondary plan shall use the covered person's recorded credit to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

C. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

1. When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

2. The requirements of Paragraph 1 of this Subsection do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§311. Notice to Covered Persons

A. A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991),

amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§315. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

1. A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (non-complying plan) on the following basis:

a. if the complying plan is the primary plan, it shall pay or provide its benefits first;

b. if the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan’s liability; and

c. if the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

2. If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

3. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

B. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

C. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no

plan shall be required to pay more than it would have paid had it been the primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§317. Severability Provision

A. If any Section or provision of Regulation 32 or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other Sections or provisions or the application of Regulation 32 to any persons or circumstances that can be given effect without the invalid section or provisions or application, and for these purposes the Sections and provisions of Regulation 32 and the applications to any persons or circumstances are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§319. Effective Date for Existing Contracts

A. A contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation, whichever occurs first, by:

1. the later of:

a. the next anniversary date or renewal date of the contract; or

b. 12 months following [insert date that the amended regulation is adopted]; or

2. the expiration of any applicable collectively bargained contract pursuant to which it was written.

B. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance pursuant to Subsection A of this Section, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§321. Appendix A—Model COB Contract Provisions

COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage except those enumerated in LSA-R.S. 22:1000 A.3C; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service

for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- (a.) The Plan covering the Custodial parent;
- (b.) The Plan covering the spouse of the Custodial parent;
- (c.) The Plan covering the non-custodial parent; and then
- (d.) The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child covered under spouse's plan

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other

Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree

longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

§323. Appendix B—Consumer Explanatory Booklet Coordination of Benefits

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state’s COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse’s Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child’s Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule”;
- or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses;
- or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary?

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary?

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary?

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:

Family Impact Statement

1. Describe the effect of the proposed regulation on the stability of the family. The proposed amended regulation should have no measurable impact upon the stability of the family.
2. Describe the effect of the proposed regulation on the authority and rights of parents regarding the education and supervision of their children. The proposed amended regulation should have no impact upon the rights and authority of children regarding the education and supervision of their children.
3. Describe the effect of the proposed regulation on the functioning of the family. The proposed amended regulation should have no direct impact upon the functioning of the family.

4. Describe the effect of the proposed regulation on family earnings and budget. The proposed amended regulation should have no direct impact upon family earnings and budget.

5. Describe the effect of the proposed regulation on the behavior and personal responsibility of children. The proposed amended regulation should have no impact upon the behavior and personal responsibility of children.

6. Describe the effect of the proposed regulation on the ability of the family or a local government to perform the function as contained in the Rule. The proposed amended regulation should have no impact upon the ability of the family or a local governmental unit to perform the function as contained in the Rule.

Poverty Impact Statement

1. Describe the effect on household income, assets, and financial security. The proposed amended regulation should have no effect on household income assets and financial security.

2. Describe the effect on early childhood development and preschool through postsecondary education development. The proposed amended regulation should have no effect on early childhood development and preschool through postsecondary education development.

3. Describe the effect on employment and workforce development. The proposed amended regulation should have no effect on employment and workforce development.

4. Describe the effect on taxes and tax credits. The proposed amended regulation should have no effect on taxes and tax credits.

5. Describe the effect on child and dependent care, housing, health care, nutrition, transportation and utilities assistance. The proposed amended regulation should have no effect on child and dependent care, housing, health care, nutrition, transportation and utilities assistance.

Provider Impact Statement

1. Describe the effect on the staffing level requirements or qualifications required to provide the same level of service. The proposed amended regulation will have no effect.

2. The total direct and indirect effect on the cost to the provider to provide the same level of service. The proposed amended regulation will have no effect.

3. The overall effect on the ability of the provider to provide the same level of service. The proposed amended regulation will have no effect.

Public Comments

In addition, all interested persons are invited to submit written comments on the proposed Rule. Such comments must be received no later than October 25, 2015 by close of business or by 4:30 p.m., and should be addressed to Claire Lemoine, Louisiana Department of Insurance and may be mailed to P.O. Box 94214, Baton Rouge, LA 70804 or faxed to (225) 342-1632. If comments are to be shipped or hand-delivered, please deliver to Poydras Building, 1702 North Third Street, Baton Rouge, LA 70804.

James J. Donelon
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Regulation 32 Group Coordination of Benefits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule will not result in implementation costs or savings to the state or local governmental units. The purpose for amending Regulation 32 is for the Department of Insurance to adopt the National Association of Insurance Commissioners' (NAIC) model regulation entitled "Coordination of benefits Model Regulation". The purpose of the regulation is to establish a uniform order of benefit determinations. This regulation applies to all plans which includes all accident and health products and health maintenance organization products that are issued on or after the effective date of this regulation.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Regulation 32 will have no impact on state or local governmental revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Regulation 32 may necessitate updates to policies and order of benefits determinations by certain insurers in order to update group benefit plans to include requirements detailed in the NAIC model regulation. This activity may create indeterminable expenses for insurance companies depending on how closely existing policies and order of benefits determinations may mirror the NAIC model, but insurers generally update policies at regular intervals and this is a standard cost of business operations for insurers.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Regulation 32 will have no impact upon competition and employment in the state.

Noble Ellington
Chief Deputy Commissioner
1509#025

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Insurance Office of the Commissioner

Regulation 104—Corporate Governance Annual Disclosure
(LAC 37:XIII.Chapter 2)

Under the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., R.S. 22:11, R.S. 22:691.34 and R.S. 22:691.35.B, notice is hereby given that the Department of Insurance proposes to promulgate Regulation 104. The purpose of Regulation 104 is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD) deemed necessary by the commission to carry out the provisions of Subpart G-2 of Part III of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:691.31 through 691.38 and to meet the accreditation requirements of the National Association of Insurance Commissioners (NAIC).

Title 37
INSURANCE

Part XIII. Regulations

Chapter 2. Regulation 104—Corporate Governance Annual Disclosure

§201. Purpose

A. The purpose of this regulation is to set forth rules and procedural requirements which the commission deems necessary to carry out the provisions of Act 304 of the 2015 Regular Legislative Session to be comprised of R.S. 22:691.31-691.38 of the Insurance Code. The information called for by this regulation is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:

§203. Definitions

Commissioner—commissioner of insurance for the state of Louisiana.

Corporate Governance Annual Disclosure or CGAD—a confidential report filed by the insurer or insurance group compiled in accordance with the requirements of R.S. 22:691.31-691.38 and Regulation 104.

Insure—shall have the same meaning as set forth in R.S. 22:46(10). For the purposes of this Subpart, a health maintenance organization as defined R.S. 22:242(7) shall also be considered an insurer. The term “insurer” shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Senior Management—any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer (“CEO”), chief financial officer (“CFO”), chief operations officer (“COO”), chief procurement officer (“CPO”), Chief Legal Officer (“CLO”), chief information officer (“CIO”), chief technology officer (“CTO”), chief revenue officer (“CRO”), chief visionary officer (“CVO”), or any other “C” level executive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:

§205. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by R.S. 22:691.33 shall, no later than June 1 of each calendar year, submit to the commission a CGAD that contains the information described in §207 of this regulation.

B. The CGAD shall include a signature of the insurer’s or insurance group’s chief executive officer or corporate secretary attesting to the best of that individual’s belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer’s or insurance group’s board of directors (hereafter “board”) or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the commission to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer’s or insurance group’s risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in R.S. 22:691.33, if the CGAD is completed at the insurance group level, then it shall be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD shall also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in §207. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

G. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing shall so state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:

§207. Contents of Corporate Governance Annual Disclosure

A. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the

governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

B. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

1. The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and

2. The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer (CEO) and chairman of the board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

1. How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group.

2. How an appropriate amount of independence is maintained on the board and its significant committees.

3. The number of meetings held by the board and its significant committees over the past year as well as information on director attendance.

4. How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example:

a. whether a nomination committee is in place to identify and select individuals for consideration.

b. whether term limits are placed on directors.

c. how the election and re-election processes function.

d. whether a board diversity policy is in place and if so, how it functions.

5. The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any board or committee training programs that have been put in place).

D. The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

1. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

a. identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

b. any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

2. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

a. compliance with laws, rules, and regulations; and

b. proactive reporting of any illegal or unethical behavior.

3. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

a. the board's role in overseeing management compensation programs and practices.

b. the various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

c. how compensation programs are related to both company and individual performance over time;

d. whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

e. any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

f. any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

4. The insurer's or insurance group's plans for CEO and senior management succession.

E. The insurer or insurance group shall describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

1. How oversight and management responsibilities are delegated between the board, its committees and senior management;

2. How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

3. How reporting responsibilities are organized for each critical risk area. The description should allow the commission to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

a. Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

b. actuarial function;

c. investment decision-making processes;

- d. reinsurance decision-making processes;
- e. business strategy/finance decision-making processes;
- f. compliance function;
- g. financial reporting/internal auditing; and
- h. market conduct decision-making processes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:

§209. Severability Clause

A. If any Section or provision of Regulation 104 or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other Sections or provisions or the application of Regulation 104 to any persons or circumstances that can be given effect without the invalid section or provision or application, and for these purposes the Sections and provisions of Regulation 104 and the application to any persons or circumstances are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:

Family Impact Statement

1. Describe the effect of the proposed regulation on the stability of the family. The proposed amended regulation should have no measurable impact upon the stability of the family.

2. Describe the effect of the proposed regulation on the authority and rights of parents regarding the education and supervision of their children. The proposed amended regulation should have no impact upon the rights and authority of children regarding the education and supervision of their children.

3. Describe the effect of the proposed regulation on the functioning of the family. The proposed amended regulation should have no direct impact upon the functioning of the family.

4. Describe the effect of the proposed regulation on family earnings and budget. The proposed amended regulation should have no direct impact upon family earnings and budget.

5. Describe the effect of the proposed regulation on the behavior and personal responsibility of children. The proposed amended regulation should have no impact upon the behavior and personal responsibility of children.

6. Describe the effect of the proposed regulation on the ability of the family or a local government to perform the function as contained in the Rule. The proposed amended regulation should have no impact upon the ability of the family or a local governmental unit to perform the function as contained in the Rule.

Poverty Impact Statement

1. Describe the effect on household income, assets, and financial security. The proposed amended regulation should have no effect on household income assets and financial security.

2. Describe the effect on early childhood development and preschool through postsecondary education development. The proposed amended regulation should have no effect on early childhood development and preschool through postsecondary education development.

3. Describe the effect on employment and workforce development. The proposed amended regulation should have no effect on employment and workforce development.

4. Describe the effect on taxes and tax credits. The proposed amended regulation should have no effect on taxes and tax credits.

5. Describe the effect on child and dependent care, housing, health care, nutrition, transportation and utilities assistance. The proposed amended regulation should have no effect on child and dependent care, housing, health care, nutrition, transportation and utilities assistance.

Small Business Statement

The impact of the proposed regulation on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed regulation that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed regulation on small businesses.

1. Identification and estimate of the number of the small businesses subject to the proposed Rule. The proposed amended regulation should have no measurable impact upon small businesses.

2. The projected reporting, record keeping, and other administrative costs required for compliance with the proposed Rule, including the type of professional skills necessary for preparation of the report or record. The proposed amended regulation should have no measurable impact upon small businesses.

3. A statement of the probable effect on impacted small businesses. The proposed amended regulation should have no measurable impact upon small businesses.

4. Describe any less intrusive or less costly alternative methods of achieving the purpose of the proposed Rule. The proposed amended regulation should have no measurable impact on small businesses; therefore, will have no less intrusive or less cost alternative methods.

Provider Impact Statement

1. Describe the effect on the staffing level requirements or qualifications required to provide the same level of service. The proposed amended regulation will have no effect.

2. The total direct and indirect effect on the cost to the provider to provide the same level of service. The proposed amended regulation will have no effect.

3. The overall effect on the ability of the provider to provide the same level of service. The proposed amended regulation will have no effect.

Public Comments

Interested persons may submit written comments on the proposed amendments to Regulation 104 until 5:00 p.m., Wednesday, October 21, 2015, to Walter Corey, Division of Legal Services, Office of the Commissioner, P.O. Box 94214, Baton Rouge, LA 70804.

James J. Donelon
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Regulation 104

Corporate Governance Annual Disclosure

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed regulation will not result in implementation costs or savings to the state or local governmental units. The purpose for Regulation 104 is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD) enacted by Act 304 of the 2015 Regular Legislative Session. All insurers domiciled in Louisiana will be required to disclose an annual CGAD. The CGAD information called for by this regulation is declared to be necessary and appropriate in the public interest and for the protection of the policyholders in the state.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed Regulation 104 will have no impact on state or local governmental revenues.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed Regulation 104 will have no fiscal impact to directly affected persons. All insurers domiciled in Louisiana will be required to disclose a CGAD with their annual report.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Regulation 104 will have no impact upon competition and employment in the state.

Denise Brignac
Deputy Commissioner
1509#061

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Public Safety and Corrections
Corrections Services**

Offender Mail and Publications (LAC 22:1.313)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, hereby gives notice of its intent to amend the contents of Section 313 Offender Mail and Publications.

Title 22

**CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT**

Part I. Corrections

Chapter 3. Adult Services

§313. Offender Mail and Publications

- A. - F.6.a.viii. ...
- ix. Greeting cards and post cards;
 - x. Decorative stationary or stationary with stickers;
 - xi. Other general correspondence for which rejection is reasonably related to a legitimate penological interest.

F.6.b. - I.1.c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:833(A), Guajardo v. Esteile, 580 F.2d 748 (5th Cir. 1978).

HISTORICAL NOTE: Promulgated by the Department of Corrections, Office of Adult Services, LR 5:4 (January 1979), amended LR 10:803 (October 1984), LR 11:360 (April 1985), amended by the Department of Public Safety and Corrections, Corrections Services, LR 33:851 (May 2007), LR 38:830 (March 2012), LR 39:2281 (August 2013), LR 41:

Family Impact Statement

Amendment to the current Rule should not have any known or foreseeable impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed Rule should not have any known or foreseeable impact on poverty as described in R.S. 49:973.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session.

Public Comments

Written comments may be addressed to Melissa Callahan, Deputy Assistant Secretary, Department of Public Safety and Corrections, P. O. Box 94304, Baton Rouge, LA 70804 until 4:30 p.m. on October 12, 2015.

James M. Le Blanc
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Offender Mail and Publications

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will have no impact on State or Local Governmental Unit expenditures. The proposed rule change updates and revised LAC 22:1.313 (Offender Mail and Publications) in accordance with the provisions of the Administrative Procedure Act (R.S. 49:950).

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections of state or local governmental units as a result of the proposed rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There is no estimated cost and/or economic benefit to directly affected persons or non-governmental groups as a result of the proposed rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment as a result of the proposed rule change.

Thomas C. Bickham, III
Undersecretary
1509#038

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Department of Public Safety and Corrections Office of Motor Vehicles

Specifications for Notification of Initiation, Termination, or Modification of Liability Security (LAC 55:III.Chapter 17)

In accordance with the provisions of R.S. 32:863.2(A)(3) and (4) for the reporting of the initiation and termination of insurance coverage, and R.S. 32:863.2(F)(6) for the development and initiation of a real-time system insurance coverage verification system, relative to the authority of the Office of Motor Vehicles, the Office of Motor Vehicles hereby publishes, and proposes to amend and readopt LAC 55:III, Chapter 17, Subchapter B, Specifications for Notification of Initiation, Termination, or Modification of Liability Security, §§1751-1764 to implement the provisions of R.S. 32:863.2(A)(3) and (4). These are completely new sections.

Additionally, In accordance with the provisions of R.S. 32:863.2(F)(6) for the development and initiation of a real-time system insurance coverage verification system, relative to the authority of the Office of Motor Vehicles, the Office of Motor Vehicles hereby publishes, and proposes to adopt LAC 55:III, Chapter 17, Subchapter C, Compulsory Insurance Enforcement, §§1766-1786 to implement the provisions of R.S. 32:863.2(A)(3) and (4). These are completely new sections.

The existing provisions of LAC 55:III.Chapter 17, Subchapter B, are being completely overwritten and will no longer be in effect upon the adoption of these rules. The existing provisions of Subchapter B which are not being overwritten are being repealed.

Title 55

PUBLIC SAFETY

Part III. Motor Vehicles

Chapter 17. Compulsory Insurance

Subchapter B. Specifications for Notification of Initiation, Termination, or Modification of Liability Security

§1750. Definitions

A. As used in this Subchapter, the following terms have the meanings described below.

Account Number/User-ID—the unique identifier assigned to each servicing agent. If the electronic filing method is via the internet, this code is assigned by GXS to identify the mailbox for the reporting entity and is also used by GXS for billing. If the electronic filing method is via the Louisiana secure server, the account number and user-id will be assigned by the department.

Business Days—business days are Monday through Friday, between 8:00 a.m. and 4:30 p.m. central time. Business days do not include Saturday, Sunday, state holidays or any other holiday declared by the governor.

Change in Coverage—a change in coverage shall be considered either an initiation of coverage or a termination of coverage based on the nature of the change. The addition of a vehicle to a liability security policy shall be considered an initiation of coverage. The effective date of the initiation shall be the date the vehicle was added to the policy, regardless of the date the original policy was issued. The

deletion of a vehicle from a liability security policy shall be considered a termination of coverage. The replacement of a covered vehicle with another vehicle in a liability security policy shall be considered both a termination of coverage for the replaced vehicle and an initiation of coverage for the replacement vehicle. If the registered owner of a vehicle changes, the previous owner's coverage shall be terminated and the new registered owner's initiation of coverage shall be reported. If the principal driver changes, but the registered owner stays the same, no change in coverage shall be reported. Renewals, without a lapse in coverage, shall not be reported. Renewals in which only the policy number changes shall not be reported. Changes in coverage not related to the vehicle liability security being issued, procured, recalled, reinstated, terminated, canceled or changed from binder status to an active policy number shall not be reported.

Department—Department of Public Safety and Corrections.

Duplicate Record—any record reported with the same information (INS-COMP-CODE, VIN, TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE and TRANSACTION-TYPE) as a record already in the Department's insurance system is a DUPLICATE RECORD and will be rejected. (Disposition code "D").

Edit Error—a record submitted by an insurance company or servicing agent unacceptable for filing purposes due to the absence of information in a required field or the presence of invalid information in the key data fields is an EDIT ERROR. Key data fields are identified and detailed in the technical filing specifications. Any record which is returned to an insurance company or servicing agent as an EDIT ERROR is not a filing. The record shall be corrected and re-reported within 15 business days of the RETURN-DATE. (Disposition code "E").

Edit Error Mask—the field within each type of record (Header, Individual Vehicle and Fleet) that is used to identify fields that failed to pass the edits. When the Disposition code is "E" the EDIT-ERROR-MASK field will identify which fields failed to pass the edits (1) and which fields are edit error free (0).

Fleet Policy—a policy insuring a business with a fleet of five or more vehicles registered in Louisiana for which VIN information is not maintained on each vehicle. If the insurance company maintains the VIN of each vehicle within the fleet, the filing must be reported on a vehicle by vehicle basis.

Hit—a record submitted by an insurance or servicing agent which matches a Department's vehicle registration record and is an acceptable record. (Disposition code "H").

Incorrect Type-Use—the reported vehicle is exempt from the Compulsory Motor Vehicle Liability Security Law because of the "type use" or "class" of vehicle. This record is not updated to the system. Do not resubmit this record. (Disposition code "I").

Initiation of Coverage—the issuing or making of a liability security policy, liability bond, deposit or other security.

Insurance Company Code—a unique number assigned to each insurance company. The National Association of Insurance Commissioners Code (NAIC code) or a temporary identification number assigned by the Department to an

insurance company for the purpose of R.S. 32:863.2 of the Compulsory Motor Vehicle Liability Security Law will be used.

Lapse—when a vehicle liability security policy is not in effect for one or more days.

No-Hit—a record submitted by an insurance company or servicing agent which does not match a Department vehicle registration record and which does not pass the VINA check. The filing must be corrected and resubmitted within 15 business days of the RETURN-DATE. (Disposition code “U”).

Non-Renewals—

a. a non-renewal of a motor vehicle liability insurance policy shall include:

- i. a refusal by the insurer to issue a superseding policy or a renewal of such policy;
- ii. a request by the insured that a superseding policy not be issued or such policy not be renewed; or
- iii. a failure of the insured to make the premium payment due upon a superseding policy or on a renewal of such policy offered by the insurer.

b. Non-renewals are to be reported in the same manner as cancellations or terminations.

Notification—the furnishing of information by a security provider to the department concerning liability security or lack of liability security on a motor vehicle, or a change or correction of data concerning the item of security, the vehicle or the lessee or owner, as required by R.S. 32:863.2 of the Motor Vehicle Liability Security Law and these rules and regulations.

Out-of-Sequence Error—the records submitted are not in chronological order. For example the cancellation is reported prior to the initiation. This record is unacceptable for filing purposes and is returned to the insurance company. Records shall be reported in chronological order. (Disposition code “S”).

Owner—the name of the legal lessee or owner as obtained by the security provider from the vehicle registration certificate.

Owner ID Number—driver’s license number for an individual, lessee or owner, the left most nine (9) characters of the driver’s license number or federal tax identification number for the lessee or owner such as a corporation, an estate, etc. This is always a required field.

Policy Number—the number of the policy that the vehicle is insured under. The insurance company will maintain a list of policy numbers and effective dates for each vehicle or fleet reported.

Prescribed—the record submitted is over 18 months old. There is an 18 month difference between the TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE or ISSUE-DATE and the date this record was received by the Department. This record is not updated to the system. Do not resubmit this record. (Disposition code “P”).

Recall of Notification—a record submitted to the department by a security provider or servicing agent, which rescinds a record previously submitted to the department in error. The recall record fields match the original record fields except for the TRANSACTION-TYPE. A transaction type “B” will recall an initiation (“A”). A transaction type “1” will recall a termination (“0”).

Record—insurance information pertaining to the items required by law and these rules and regulations for an individual vehicle or fleet coverage.

Return Filing Report—a report prepared by the department for an insurance company or servicing agent following completion of processing (editing of data and record matching) containing the disposition of each record. It is the responsibility of the insurance company or servicing agent to review this report and take the necessary corrective action as required by these rules and regulations. If the return report contains only the header record, that record was submitted with incorrect or missing information. In this case, the header record must be corrected and all of the filing records must be resubmitted. None of the filing records submitted with an incomplete or incorrect header record will be accepted. Please note the Office of Motor Vehicles is not responsible for keeping a copy of this report.

Restricted Hit—a record submitted by an insurance company or servicing agent which does not match a Department vehicle registration record but which does pass the VINA edit check. These records do not need to be re-reported. (Disposition code “R”).

Return Date—the department will provide a return date in its filing report. The return date will be the date the Department writes the filing report and will equal the date in the DATE-PROCESSED field of the trailer record.

Security Provider—a liability insurance company or other provider of liability security required under the Compulsory Motor Vehicle Liability Security Law (R.S. 32:861 et seq.).

Service Agent—any person or organization duly designated by an insurance company to prepare, transmit or deliver records on behalf of such insurance company.

Service Agent Code—a number assigned to each service agent. Either the National Association of Insurance Commissioners Code (NAIC code) or a temporary identification number assigned by the department will be used.

Termination/Cancellation of Liability Security—any cancellation or termination of liability security on a motor vehicle (whether caused by the insurer or insured).

Timely Filing—notification received within 15 business days from the issue date when a vehicle’s liability security is issued, procured, recalled, reinstated, terminated, canceled or changed from binder status to an active policy number.

VINA—routine used to compute the VIN check digit for 1981 or newer vehicles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2842 (December 2004); LR 41:

§1752. Introduction

A. Effective July 1, 1998, security providers shall report to the Department of Public Safety and Corrections, Office of Motor Vehicles, certain information, on a vehicle by vehicle basis, with certain exceptions, in accordance with the Compulsory Motor Vehicle Liability Security Law (R.S. 32:861 et. seq.) “the compulsory security law” and with these rules and regulations regarding the initiation of liability coverage as well as the termination, withdrawal,

cancellation, lapsing or otherwise rendering ineffective of liability coverage.

B. As required by law and these rules and regulations, reports must be made to the department whenever liability security on a vehicle is issued, procured, recalled, reinstated, terminated, canceled or changed from binder status to an active policy number.

C. Such information must be transmitted to the department in an efficient and timely manner in accordance with these rules and regulations.

D. Insurance companies shall not provide information to the department except as required by law or these rules and regulations. Examples of information which will not be submitted to the department include, but are not limited to, the following:

1. information on non-liability coverage such as collision and comprehensive policies;
2. information of liability policies not in compliance with the compulsory security law (such as umbrella policies with excess coverage and non-ownership policies);
3. addition or deletion of other drivers;
4. change of policy number;
5. invalid type use or class.

E. The purpose of the information required is to enforce the Motor Vehicle Safety Responsibility Law (R.S. 32:851 et. seq.) and particularly the compulsory security law (R.S. 32:861 et. seq.). Consistently with this purpose, the information maintained by the department will be provided to a person making proper written request under R.S. 32:863.2.C and R.S. 32:871, only after an accident is reported in accordance with R.S. 32:871. Information will be provided on a single individual or vehicle basis only. In order to preserve the proprietary information of insurance companies, insurance coverage information compiled by company or by zip code, for example, will not be made available to inquirers, nor will the department develop or maintain any composite list by insurance company or insurance company identifier except by count of disposition codes. The department will cooperate fully with the insurance industry in preserving the security of customer lists and related data. The department will initiate criminal prosecution for violations arising out of the wrongful taking or use of information reported under these rules and regulations.

F. The intent of these rules and regulations is to provide a mechanism whereby the liability security coverage for each vehicle subject to the compulsory security law is identified, with the least necessary intrusion into the proprietary interests of liability security providers. To that end the department, responding to the expressed concerns of the insurance industry, has attempted to eliminate unnecessary redundancy in the data required to be reported. To the extent that any adjustments are required in the scope of reportable information, the department solicits the continuing active cooperation of the insurance industry in maintaining the effective operation of the compulsory security law.

G. These rules and regulations permit adjustments to technical specifications. Security providers will be advised by mail (postal, electronic or both) of any changes in the technical specifications of this Section. The department will always attempt to give 90 days notice of these adjustments

so that the security provider may have enough time to implement the changes, however, legislative changes or other circumstances may result in notice of less than 90 days. Such mailings may be called "advisory bulletins" or "memorandums" from the Commissioner of the Office of Motor Vehicles. These bulletins or memorandums may also contain clarifications, helpful hints and such additional information as may be deemed applicable to compliance with the compulsory security law. Moreover, in the event that an unusual situation is not covered by these regulations, a reasonable procedure consistent with the compulsory security law will be followed.

H. In cases where, after written notice, a security provider continually fails to supply the information required by R.S. 32:863.2 and these rules and regulations, fees as provided by that statute may be imposed. A security provider will not be charged a fee for providing data based on a reasonable assumption, such as assuming in good faith that the owner's driver's license number is the same as the named insured's driver's license number. Special consideration shall be given to unusual problems in compliance, provided in writing.

I. A security provider must notify the department when motor vehicle liability security is issued or procured or after motor vehicle liability security is recalled, reinstated, terminated, canceled or changed from binder status to an active policy number. For initiations and terminations such notification shall be made within 15 business days of the issue date. Notification shall be made in the form required by the department as set forth in these rules and regulations. A separate notice shall be submitted for each vehicle. Failure to properly notify the department may result in administrative fees.

J. Procedural questions concerning this regulation should be referred to (email is the preferred method of communication):

1. Mailing Address:

Louisiana Department of Public Safety and Corrections
Office of Motor Vehicles
Post Office Box 64886
Baton Rouge, LA 70896
Attention: Compulsory Insurance Unit

2. Phone Number: (225) 925-7285 or (225) 925-3731
3. Email: Insurance@dps.la.gov
4. Fax Number: (225) 922-0158

K. Technical questions concerning this regulation should be referred to (email is the preferred method of communication):

1. Mailing Address:

Louisiana Department of Public Safety and Corrections
Data Processing Center
8001 Independence Boulevard
Baton Rouge, LA 70806
Attention: DMB Project Leader

2. Phone Number : (225) 922-2260
3. Email: Insurance@dps.la.gov
4. Fax Number: (225) 925-4019

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004); amended LR 41:

§1754. General Information

A. Correcting No-Hits. A “Hit” is based on the VIN number. When the VIN does not match with the department’s vehicle registration records and fails the VINA check, the record is coded “No-Hit” (Disposition code “U”). In accordance with these rules and regulations, the security provider (insurance company) has 15 business days from the return date of the filing to correct the VIN information and resubmit. If a company provides a VIN for a 1981 or newer vehicle and the department’s VINA check determines that the VIN is valid, but the VIN is not available from the department’s vehicle registration records, the record is returned as a “Restricted Hit”. (Disposition code “R”).

B. Reporting an Initiation of Coverage and Cancellation of Coverage at the Same Time. The last record received from a company for a vehicle is considered to reflect the status of the vehicle with the company. Multiple filings for a single vehicle having the same company code and owner-ID will result in the last record received being maintained by the department. Receiving records out of order remains a problem with many companies and may result in cancellation notices being sent to individuals who have insurance. All records must be submitted in chronological order.

C. Recalling Notification. When a security provider discovers that a cancellation or initiation of coverage was reported by mistake, the security provider shall submit to the department a notice of recall of notification. All of the data except the transaction type shall be the same as originally submitted in order to match the recall with the notification. A transaction type “B” will recall an initiation (“A”). A transaction type “1” will recall a termination (“0”).

D. Warning on Notice of Acknowledgment of Termination to Insured. The notice of acknowledgment of termination sent to an insured shall contain the following warning notice:

1. If you do not keep your liability insurance in force during the entire registration period, your registering privileges will be subject to revocation. By law your insurance carrier is required to report specific termination information to the Commissioner of the Department of Public Safety and Corrections.

E. Timely Insurance Filings. In accordance with these rules and regulations, the security provider must notify the department when motor vehicle security is begun, issued or procured or after motor vehicle security is ended, recalled, reinstated, terminated, canceled or changed from a binder status to an active policy number. Such notification must be made within 15 business days from the issue date. The security provider has 15 business days from receipt of the department’s returned filings to correct any “No-Hit” records and resubmit. Termination filings received prior to the effective date will result in an edit error (Disposition code “E”). An edit error is not an acceptable filing. Edit errors must be corrected and resubmitted. It is the responsibility of the insurance company or servicing agent to review and take the necessary corrective action as required by these rules and regulations. An initiation or termination filing will be

considered late if the date received is more than 15 business days after the issue date. Any filings considered late will be returned with the LATE-FLAG set to “Y”.

1. Possible Policy Scenarios. If a policy lapses and is then later reinstated, with a lapse, submit a termination. Whenever the policy is re-issued, send in the initiation with the new initiation date, not the date that the policy was initially issued.

a. If insurance coverage lapses and is reinstated without a lapse and a termination has been submitted, recall the termination. Do not send in a new initiation.

b. If insurance coverage lapses and is reinstated without a lapse and a termination was not submitted, no filings are required. Only valid terminations should be reported.

c. If the policy number changes or if the policy is renewed without any owner ID or vehicle or company (NAIC number) changes, then a filing is not required.

2. The department will monitor this area of the reporting requirements. Those security providers who violate this provision will be subject to possible fee assessments.

F. Manual Filings. Effective January 1, 2005 the department will no longer accept manual filings.

G. Fleet Filings—Guidelines for Fleet Filings

1. Eligibility. Any insurance company writing motor vehicle liability insurance in Louisiana and insuring a fleet of five or more vehicles registered in Louisiana for which VIN information is not maintained on each vehicle must electronically report said fleet coverage as specified in these rules and regulations. If the insurance company maintains the VIN number of each vehicle within the fleet, the filing must be reported on a vehicle by vehicle basis.

2. Conditions of Filing. A security provider must notify the department after motor vehicle liability security is begun, ended or in certain ways modified. Such notification shall be made within 15 business days of the issue date of initiation termination of coverage. After the initiation has been reported, the cancellation is not to be reported until the entire Fleet policy has been canceled. (Do not report the addition or deletion of individual vehicles.)

3. Format. Each notification must be transmitted electronically using the formats provided in these Rules and Regulations.

4. Number of Vehicles. The estimated number of vehicles in a fleet is reported in lieu of VIN information on a vehicle by vehicle basis.

H. Fee Assessments

1. The Louisiana Department of Public Safety and Corrections is charged with administering and enforcing all compulsory insurance provisions. In so doing, we must rely on the cooperation of the insurance industry to provide timely, complete and accurate information in accordance with R.S. 32:863.2 and these rules and regulations.

2. Failure to report the required information and/or failure to report the required information timely can result in the insurance company being assessed a fee. If any of acceptable filings (Disposition codes Hit and Restrict Hit) are considered late, a fee of \$50 may be assessed for each of these late filings. A fee of \$50 may be assessed for each failure to report.

3. This state’s vehicle registration records will be checked against liability security insurance records on an

ongoing basis. Fees will be assessed to those companies in non-compliance with the statute and these rules and regulations. Further, in cooperation with the Department of Insurance, continuous violations and non-compliance could result in additional administrative or judicial action.

4. Fees will not be assessed to those security providers who continue to report all insured vehicles, as well as reporting them in a timely manner.

I. Transaction Types and How They are Used. Described below are the transaction types and how each may be used:

1. 0-Termination. A termination or cancellation notice is submitted whenever liability security is canceled or terminated.

2. 1-Recall of Termination. The recall of transaction type "0" is used whenever a cancellation notice has previously been sent in error.

Example: A cancellation notice was incorrectly reported. The cancellation date was reported as February 2 instead of February 13. A recall of the February 2 cancellation notice is submitted followed by a cancellation notice having a cancel date of February 13.

3. 6-Termination for NSF Check. A termination or cancellation notice pursuant to this code is submitted whenever a Security Provider backdates the effective date of a cancellation because the insurer paid with a check that was returned by the bank more than 15 days after the effective date of the policy.

4. 7-Termination for Rescinded/Canceled Sale. A termination or cancellation notice is submitted whenever liability security is canceled or terminated as a result of a rescinded or canceled sale of the vehicle.

5. A-Initiation. An initiation notice is submitted whenever liability security is initiated (new business) on a vehicle. If there is a lapse in coverage, a termination notice must be submitted followed by an initiation notice showing the new initiation or reinstated date.

6. B-Recall of Initiation. The recall of transaction type "A" is used whenever an initiation notice is submitted in error.

Example: An initiation notice was incorrectly reported. The starting date was reported as February 2 instead of February 13. A recall of the February 2 initiation notice is submitted followed by an initiation notice having a starting date of February 13.

7. F-Change. A change notice is submitted only for changing the policy number from "BINDER" to an active policy number.

Example: An initiation notice was submitted with a policy number of "BINDER". A change notice is submitted with an active policy number.

J. Disposition Codes. Described below are the disposition codes returned and how they are used.

1. D-Duplicate Reporting. This record was previously reported to the department with the same information. This record has been rejected by the department. It is not necessary to re-report the same record again after it was successfully reported.

2. E-Edit Error. This record is not acceptable due to the absence of information in a required field or invalid information in a field. This record has been rejected by the department. The EDIT-ERROR-MASK field needs to be evaluated to determine the field(s) that requires amendment. After the field(s) have been corrected this record shall be re-reported.

3. H-Hit. This record has been accepted by the department. This record's VIN matches a vehicle that requires compulsory liability security and is currently registered in Louisiana.

4. I-Incorrect Vehicle "Type Use" or "Class". This record has been rejected by the department. The "type use" or "class" of this vehicle record is such that it does not have to be reported to the department. An example of this type of vehicle is a trailer.

5. P-Prescribed. This record is not acceptable because the date in the TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE or ISSUE-DATE field is more than 18 months old. This record has been rejected by the department.

6. R-Restricted Hit. This record has been accepted by the department. The VIN of this record does not match a vehicle currently registered in Louisiana that requires compulsory insurance; however, the VIN reported passes the VINA edit routine. This record should be verified using the vehicle registration certificate.

7. S-Sequence Error. This record has been rejected by the department. The record has been reported out of sequence. Examples are: reporting a transaction type "0" (termination) prior to having reported a transaction type "A" (initiation). Records shall be reported in chronological order.

8. U-No-Hit. This record has been rejected by the department. The VIN of this record does not match a vehicle currently registered in Louisiana. The VIN does not pass the VINA edit routine. The record should be verified using the vehicle registration certificate.

K. Contact Person Information

1. Certain information is needed periodically by this agency to facilitate communication with security providers. The contact information sheet is to be completed and returned to the department during the month of January each year and whenever there is a change involving contact personnel. A contact information sheet shall be submitted for each insurance company.

2. Please furnish the name of the representative responsible for compliance:

- a. administrative reporting requirements;
- b. information technology/information services/data processing;
- c. commercial lines;
- d. personal lines;
- e. fleet filings;
- f. other personnel responsible for filings or fee assessment.

L. Contact Person Information Sheet (CPIS). A CPIS shall be completed by every insurance company:

**CONTACT PERSON INFORMATION SHEET
LA. OFFICE OF MOTOR VEHICLES
COMPULSORY INSURANCE UNIT
P.O.BOX 64886
BATON ROUGE, LA 70896**

Certain updated information is needed periodically by this agency in order for us to contact the correct person within your insurance company to provide the most updated information or to correct problem areas.

The contact information sheet is to be completed and returned to this department. The contact sheet must be submitted during the month of January each year and whenever there is a change in any of your company's contact personnel.

A contact information sheet must be submitted for each insurance company.

Please furnish the name of the representative for compliance with administrative reporting requirements, data processing, commercial lines, personal lines, fleet filings and other personnel responsible for filings or fee assessments.

This information will assist us in contacting your company's representative(s) in regard to specific compliance regulations:

NAIC#	NAME OF INSURANCE COMPANY
ADMINISTRATIVE COMPLIANCE	DATA PROCESSING
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE: ()	PHONE: ()
FAX: ()	FAX: ()
E-MAIL ADDRESS:	E-MAIL ADDRESS:

AREA OF RESPONSIBILITY	AREA OF RESPONSIBILITY
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE: ()	PHONE: ()
FAX: ()	FAX: ()
E-MAIL ADDRESS:	E-MAIL ADDRESS:

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004), amended LR 41:

§1756. Reporting Instructions

A. The Louisiana Department of Public Safety and Corrections has two acceptable methods of exchanging electronic data for compulsory liability insurance reporting.

B. One method is to utilize GXS's "information exchange" service. The "information exchange" service will allow secure electronic data transfer between the department and each insurance company. The "information exchange" service gives you the option of submitting multiple filings per day. A message class should be used when sending files via GXS to the test or production mailbox. The message class for uncompressed files is LAPS however the department no longer accepts compressed files. The following outlines steps necessary to begin participating in this electronic transfer. Assistance in implementing the insurance company's part of this electronic relationship will be provided by the marketing and enabling support function which can be reached at (877) 326-6426. The department's mailbox (account-number/user-id) is: "LAPS/LAPSS67" for test; "LAPS/LAPSS68" for production. Please do not send more than 50,000 records at one time. For more records,

split the file into smaller parts and send these individually. Each part must contain one header and one trailer.

1. A test filing shall be submitted for all new companies. Please ensure that the test files are sent to the test mailbox (LAPS/LAPSS67) and that all testing has been completed before sending a file to the production mailbox.

2. Network Connectivity/Mailbox. Security providers that currently have connectivity to GXS, either through Insurance Value Added Network Services ("IVANS" phone number (800) 548-2675) or directly, must ensure that their network account is attached to the "information exchange" service. Marketing and Enabling Support can verify this for you. If you do not currently have an account with GXS and would like one, or if you currently access a mailbox for which restrictions prevent use of that mailbox in this effort, you can obtain an account. Please contact Marketing and Enabling Support at the number noted above.

3. Cost Information. Information for costs related to participation in this activity (network charges, software charges, etc.) will be provided by the individuals/groups noted above. Costs incurred through participation in this electronic transfer of data will be the responsibility of the filing security provider, not the department.

4. After contacting GXS, please provide the department with the NAIC number, account number and user ID at Insurance@dps.la.gov

C. The second method is the state of Louisiana's free DMZ MoveIt server. You may only submit one filing per day. The following outlines the steps necessary to begin participating in this method of electronic transfer. You will need to contact the department at Insurance@dps.la.gov to obtain a security form. This form must be completed, signed, scanned and emailed back to the department for processing. An account will be created for you. Once the account is created you will receive a flow chart with the file names required for you to submit your filings and to retrieve your return error files. You will be required to submit a test file. If the test file is successful then you will be able to go to production.

D. General Information

1. All record formats for electronic transfer will be as described below in the section entitled record formats.

2. The department will retrieve filings only once per day. Any filing not sent before this retrieval time will be considered filed on the next day.

3. After processing, information will be returned to the appropriate GXS mailbox or DMZ MoveIt server folder. The returned data will then be ready to be accessed by the insurance company.

4. Please process the return files prior to sending in any additional files.

E. File Transfer. The department will transfer all files using the FTP protocol. Therefore all files will need to be placed in the department's mailbox using FTP or in FTP ASCII format which uses a CRLF (carriage return line feed) pair as the end-of-line character sequence.

F. Record Processing

1. The filing record will have: a header record, filing records (individual vehicle or fleet) and a trailer record. The trailer record will consist of all 9's from character 1 through character 219. Character number 220 of the trailer record should have a transaction type of "2". After processing the

filing records, the department will return the filing report to the insurance company's GXS mailbox or DMZ MoveIt server folder. The report will consist of: the header record, filing records with dispositions and late flags and a trailer record containing summary totals.

2. Upon receipt, filings will be edited for the purpose of verification of format and reporting requirements identifying missing or invalid data. Accepted records (those without edit errors) will then be compared by VIN with departmental vehicle registration files. After these steps, records that do not result in a match will be considered unresolved. It is the responsibility of the insurance company to read the returned filing. No-Hit (Disposition code "U") and Edit-Error (Disposition code "E") exceptions must be corrected and re-submitted within fifteen (15) business days from the receipt of the returned filing. If an Out-of-Sequence (Disposition code "S") error is received contact the department as soon as possible before trying to make corrections to avoid filing errors that cannot be corrected.

G. Record Formats

1. There are four types of records: header, individual vehicle filing, fleet filing and trailer.

2. A header record must be the first record on filings submitted to the department. This record contains information pertaining to a particular filing as well as the account number and user-id of the reporting service agent. This information is critical for preparing the department's return report. The header record will be the first record on the department's return report and will have a record type of "3".

3. An individual vehicle filing record is used by an insurance company for reporting required liability security information for an individual vehicle. This filing record will have a record type of "1".

4. A fleet filing record is used by an insurance company for reporting required liability security information for a fleet of vehicles. This filing record will have a record type of "4".

5. Header Record

a. The header record has a record type = "3" and it will be edited for errors. It must be the first record on the filing. Filings will not be processed if the header record does not pass all edit checks. If an error is encountered, the header record will be the only record written to the return report. Character positions (194-218) of the header will have an EDIT-ERROR-MASK. The field(s) in error must be corrected and the record(s) re-submitted for processing.

b. Header Record Field Descriptions

i. SERV-AGENT-CODE—code for an insurance company preparing its own filing, or a department-supplied number. The service agent code must be the same throughout the entire filing report.

ii. NR-FILING-RECORDS—number of filings records, excluding header and trailer records. An accurate count for this field is not required. It must have 6 digits but it can be 6 zeros.

iii. DATE-CREATED—date the filing report was created. Use format CCYYMMDD.

iv. TEST-FILE—indicator to determine if filing report is production or test. Use "Y" for test data or "N" for live data. If the indicator is "Y", filing reports for GXS must be sent to the Test mailbox ("LAPS/LAPSS67").

- v. COMPRESSION—use "N" for uncompressed.
- vi. ACCOUNT-NUMBER—the account number (assigned to the company by the GXS or the department).
- vii. PERIOD—the character ".".
- viii. USER-ID—the user ID (assigned to the company by the GXS or the department).
- ix. INS-CO-USAGE—this field is for insurance company usage.
- x. FILLER—unused. Should be space filled.
- xi. EDIT-ERROR-MASK—used by the department to identify fields in error if the disposition code is "E".

xii. DISPOSITION—if the header record is acceptable will be a SPACE, if the header record is unacceptable will be "E".

xiii. RECORD-TYPE—use a "3".

c. The following fields are required, and the absence of any of these key data fields or the presence of invalid data in any of the key data fields is an edit error which precludes the department from processing any filing records on the submission.

- i. SERV-AGENT-CODE
- ii. NR-FILING-RECORDS
- iii. DATE-CREATED
- iv. TEST-FILE
- v. COMPRESSION
- vi. ACCOUNT-NUMBER
- vii. PERIOD
- viii. USER-ID
- ix. RECORD-TYPE

d. Returning Edit Errors. For a header record with an "E" disposition, the EDIT-ERROR-MASK field will be used to indicate the fields in error. Positions are as follows.

- i. SERV-AGENT-CODE 194
- ii. NR-FILING-RECORDS 195
- iii. DATE-CREATED 196
- iv. TEST-FILE 197
- v. COMPRESSION 198
- vi. ACCOUNT-NUMBER 199
- vii. PERIOD 200
- viii. USER-ID 201
- ix. RECORD-TYPE 202

e. A value of "1" in any of the above character positions in Subparagraph "d" above signifies an error in the corresponding item. For example, if the SERV-AGT is missing, character position 194 will have a value of "1". A value of "0" in any character position of the EDIT-ERROR-MASK signifies that the corresponding item passed the edits.

6. Individual Vehicle Filing Record

a. An individual vehicle filing record identifies the vehicle for which liability security has been issued, procured, recalled, reinstated, terminated, canceled or changed from binder status to an active policy. Every individual vehicle filing record in the RETURN FILING REPORT is to be reviewed. Duplicate reportings (Disposition code "D") are not to be re-reported to the department. Edit errors (Disposition code "E") are to be corrected and re-reported to the department within 15 business days of the return-date. Hits (Disposition code "H") are acceptable. Incorrect "type use" or "class" (Disposition code "I") are not to be re-reported to the department.

Prescribed (Disposition code “P”) are not to be re-reported to the department. Restricted-Hit (Disposition code “R”) are to have the “VIN” verified with the “vehicle identification number” field from the vehicle registration certificate. If the “VIN” reported matches the “vehicle identification number” on the vehicle registration certificate, do not re-report. If the “VIN” reported does not match the “vehicle identification number” on the vehicle registration certificate, re-report with the correct “VIN”. Sequence errors (Disposition code “S”) must be researched to determine if the record needs to be resubmitted with necessary changes. Records must be reported in chronological order. No-Hit (Disposition code “U”) are to have the “VIN” verified with the “vehicle identification number” field from the vehicle registration certificate, corrected and re-reported with the correct “VIN”; this is not an acceptable reporting.

b. Individual Vehicle Filing Record Field Descriptions

- i. VIN—“vehicle identification number” field from the vehicle registration certificate.
- ii. INS-COMP-CODE—NAIC Code (best’s insurance reports property-casualty).
- iii. TRANSACTION-TYPE—see Section III.I. (Transaction Types and How They Are Used)
- iv. INS-POLICY-NR—policy number.
- v. TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE—date insurance coverage on VIN was canceled, terminated, changed or became effective. Use format CCYYMMDD.
- vi. SERV-AGENT-CODE—use only one servicing agent code throughout the filing. Companies preparing their own filings are to use the NAIC code for the company reporting. Servicing Agents preparing filings for multiple companies shall use their SERV-AGENT-CODE throughout the entire filing and use the NAIC code for the insurance company that is issuing the liability security policy in the INS-COMP-CODE field.
- vii. LESSEE-OR-OWNER-STATE—a two-character abbreviation for the state that issued the driver’s license. If the “LESSEE-OR- OWNER-IDENTIFICATION-NUMBER” contains the federal tax identification number, the LESSEE-OR-OWNER-STATE field is spaces.
- viii. LESSEE-OR-OWNER-IDENTIFICATION-NUMBER—the lessee or owner identification number can be either a driver’s license number or a federal tax identification number. The “DRIVER’S LICENSE/EIN” field as it appears on the vehicle registration certificate should contain the correct number. For individually owned vehicles, use the driver’s license. For company owned vehicles, use the federal tax identification number.
- ix. ISSUE-DATE—date the policy was issued or terminated for a vehicle. When reporting an initiation for a new vehicle added to an existing policy, make sure that the issue date used is the date the vehicle was added to the policy, not the issue date of the original policy. Use format CCYYMMDD.
- x. INS-CO-USAGE—this field is for insurance company usage.
- xi. FILLER—spaces. No special characters.
- xii. RETURN-DATE – This field will be populated by the department with the date the record was processed

and returned to the reporting company. Use format CCYYMMDD.

xiii. LATE-FLAG—indicates if filing record was late. This field will be populated by the department. Any filing that is late will have this field set to “Y”.

xiv. EDIT-ERROR-MASK—used to identify edit errors that are being returned to the company. For filing records with DISPOSITION of “E” the EDIT-ERROR-MASK will identify each field that failed to pass the edits. This field will be populated by the department with a “1” (error) or “0” (no error).

xv. DISPOSITION—code used to determine the acceptance or rejection of a filing record. This field will be populated by the department. See Section III.J. (Disposition Codes)

xvi. RECORD-TYPE—use a “1” to identify this record as an individual vehicle filing record.

c. The following fields are required, and the absence of any of these key data fields or the presence of invalid data in any of the key data fields is an edit error which precludes the department from processing this individual filing record.

- i. VIN
- ii. INS-COMP-CODE
- iii. TRANSACTION-TYPE
- iv. INS-POLICY-NR
- v. TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE
- vi. SERV-AGENT-CODE
- vii. LESSEE-OR-OWNER-STATE
- viii. LESSEE-OR-OWNER-IDENTIFICATION-NUMBER
- ix. ISSUE-DATE
- x. RECORD-TYPE

d. Returning Edit Errors. For individual vehicle filing records with an “E” disposition, the EDIT-ERROR-MASK field will be used to indicate the fields in error. Positions are as follows:

i. VIN	194
ii. INS-COMP-CODE	195
iii. TRANSACTION-TYPE	196
iv. INS-POLICY-NR	197
v. TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE	198
vi. SERV-AGENT-CODE	199
vii. LESSEE-OR-OWNER-STATE	200
viii. LESSEE-OR-OWNER-IDENTIFICATION-NUMBER	201
ix. ISSUE-DATE—only for Initiations	202
x. RECORD-TYPE	203

e. A value of “1” in any of the above character positions signifies an error in the corresponding item. For example, if the TRANSACTION-TYPE is missing, character position 196 will have a value of “1”. A value of “0” in any character position of the EDIT-ERROR-MASK signifies that the corresponding item has passed the edits.

7. Fleet Filing Record

- a. A fleet filing record is to be used to report the number of vehicles contained within the fleet.
- b. Fleet Filing Record Field Descriptions

1. INS-COMP-CODE—NAIC Code (Best’s Insurance Reports Property-Casualty)
2. TRANSACTION-TYPE—see Section III.I. (Transaction Types and How They Are Used)
3. INS-POLICY-NR—policy number.
4. TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE—date policy was canceled, terminated, changed or became effective. Use format CCYYMMDD.
5. SERV-AGENT-CODE—use only one servicing agent code throughout the filing. Companies preparing their own filings are to use the NAIC code for the company reporting. Servicing Agents preparing filings for multiple companies shall use their SERV-AGENT-CODE throughout the entire filing and use the NAIC code for the insurance company that is issuing the liability/security policy in the INS-COMP-CODE field.
6. LESSEE-OR-OWNER-FEDERAL-TAX-IDENTIFICATION-NUMBER—The lessee or owner Federal Tax Identification Number. Use the 9 digits of the federal tax identification number. This is the “DRIVER’S LICENSE/EIN” FIELD as it appears on the vehicle registration certificate.
7. LESSEE-OR-OWNER-NAME—for leased vehicles (“STATUS” field of the vehicle registration certificate is “LESSEE”) this is the “NAME” field as it appears on the vehicle registration certificate. For owned vehicles, this is the “OWNER’S NAME” field as it appears on the vehicle registration certificate.
8. LESSEE-OR-OWNER-ADDRESS—for leased vehicles (“STATUS” field of the Vehicle Registration Certificate is “LESSEE”) this is the “STREET1” field below the “NAME” field as it appears on the vehicle registration certificate. For owned vehicles, this is the “STREET1” field below the “OWNER’S NAME” field as it appears on the vehicle registration certificate.
9. LESSEE-OR-OWNER-CITY-STATE—for leased vehicles (“STATUS” field of the vehicle registration certificate is “LESSEE”) this is the “CITY/STATE” field below the “NAME” field as it appears on the vehicle registration certificate. For owned vehicles, this is the “CITY/STATE” field below the “OWNER’S NAME” field as it appears on the vehicle registration certificate.
10. LESSEE-OR-OWNER-ZIP-CODE—for leased vehicles (“STATUS” field of the vehicle registration certificate is “LESSEE”) this is the “ZIP” field below the “NAME” field as it appears on the vehicle registration certificate. For owned vehicles, this is the “ZIP” field below the “OWNER’S NAME” field as it appears on the vehicle registration certificate.
11. NUMBER-OF-VEHICLES-IN-FLEET—the estimated number of vehicles in the fleet covered by this filing record.
12. ISSUE-DATE—date the policy was issued or terminated.
13. INS-CO-USAGE—this field is for insurance company usage.
14. RETURN-DATE—this field will be populated by the department with the date the record was processed and returned to the reporting company. Use format CCYYMMDD.
15. LATE-FLAG—indicates if filing was late. This field will be populated by the department. Any filing that is late will have this field set to “Y”.
16. EDIT-ERROR-MASK—used to identify edit errors that are being returned to the company. For filing records with disposition of “E”, the EDIT-ERROR-MASK will identify each field that failed to pass the edits. Each character of this field will be populated by the department with a “1” (error) or a “0” (no error).
17. DISPOSITION—code used to determine the acceptance or rejection of a filing record. This field will be populated by the department. See Section III.J. (Disposition Codes)
18. RECORD-TYPE—use a “4” to identify this record as a fleet filing record.

c. The following fields are required.

- i. INS-COMP-CODE
- ii. TRANSACTION-TYPE

- iii. INS-POLICY-NR
- iv. TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE
- v. SERV-AGENT-CODE
- vi. LESSEE-OR-OWNER-FEDERAL-TAX-IDENTIFICATION-NUMBER
- vii. LESSEE-OR-OWNER-NAME
- viii. LESSEE-OR-OWNER-ADDRESS
- ix. LESSEE-OR-OWNER-CITY-STATE
- x. LESSEE-OR-OWNER-ZIP-CODE
- xi. NUMBER-OF-VEHICLES-IN-FLEET
- xii. ISSUE-DATE
- xiii. RECORD-TYPE

d. Returning Edit Errors

i. For filing records with an “E” disposition, the EDIT-ERROR-MASK field will be used to indicate the fields in error. Positions are as follows:

(a). INS-COMP-CODE	194
(b). TRANSACTION-TYPE	195
(c). INS-POLICY-NR	196
(d). TERMINATION-OR-CHANGE-OR-EFFECTIVE-DATE	197
(e). SERV-AGENT-CODE	198
(f). LESSEE-OR-OWNER-FEDERAL-TAX-IDENTIFICATION-NUMBER	199
(g). LESSEE-OR-OWNER-NAME	200
(h). LESSEE-OR-OWNER-ADDRESS	201
(i). LESSEE-OR-OWNER-CITY-STATE	202
(j). LESSEE-OR-OWNER-ZIP-CODE	203
(k). NUMBER-OF-VEHICLES-IN-FLEET	204
(l). ISSUE-DATE	205
(m). RECORD-TYPE	206

ii. A value of “1” in any of the above character positions signifies an error in the corresponding item. For example, if the TRANSACTION-TYPE is missing, character position 195 will have a value of “1”. A value of “0” in any character position of the EDIT-ERROR-MASK signifies that the corresponding item passed the edits.

8. Trailer Record

a. A trailer record is required. The trailer record must contain all 9’s for positions 1 through 219 and must have a record type 2 in position 220. After the complete filing has been processed, the department will update the trailer record with statistical information for the records submitted. This record is returned to the insurance company for review.

b. Returned Trailer Record Field Descriptions:

- i. Servicing Agent Code
- ii. Date Filing was Received by the department \
- iii. Date Filing was Processed by the department
- iv. Total number of records included in the filing (record types 1 and 4)
- v. Total number of records with disposition “D” (Duplicate Reporting)
- vi. Total number of records with disposition “E” (Edit Error)
- vii. Total number of records with disposition “H” (Hit)
- viii. Total number of records with disposition “I” (Incorrect Type-Use or Class)
- ix. Total number of records with disposition “P” (Prescribed)

- x. Total number of records with disposition “R”
(Restricted Hit)
- xi. Total number of records with disposition “S”
(Sequence Error)
- xii. Total number of records with disposition “U”
(No Hit)

- xiii. Total number of late filings
- xiv. Filler
- xv. Record-Type – 2

H. Record Format—Insurance Header Record

FIELD CHARACTERISTICS		RECORD NAME		SYSTEM		
A = ALPHABETIC X = ALPHANUMERIC N = NUMERIC (UNSIGNED) USAGE ALL ASCII CHARACTERS		INSURANCE HEADER RECORD		Compulsory Insurance Reporting		
				RECORD SIZE		
				220		
ITEM NO.	FIELD POSITION	FIELD SIZE CHAR.	FIELD CHAR.	JUSTIFIED	FIELD LABEL	DESCRIPTION OR VALUE
1	1 - 5	5	N	Right	Serv-Agent-Code	REQUIRED
2	6 - 11	6	N	Right	NR-Filing-Records	REQUIRED
3	12 - 19	8	N	Right	Date-Created	REQUIRED
4	20	1	X		Test-File (Y or N)	REQUIRED
5	21	1	X		Compression (Y or N)	REQUIRED
6	22 - 28	7	X	Right	Account-Num	REQUIRED
7	29	1	X		Period	REQUIRED
8	30 - 36	7	X	Right	User-ID	REQUIRED
9	37 - 70	34	X		Ins-Co-Usage	
10	71 - 193	123	X		Filler	SPACES
*** THE FOLLOWING FIELDS ARE OMV DATA RETURNED FOR RECORD TYPE = 3 ***						
11	194 - 218	25	X	Left	Edit-Error-Mask	
12	219	1	X	Left	Disposition	
13	220	1	N		Record-Type	3

I. Record Format—Individual Vehicle Filing Record

FIELD CHARACTERISTICS		RECORD NAME		SYSTEM		
A = ALPHABETIC X = ALPHANUMERIC N = NUMERIC (UNSIGNED) USAGE ALL ASCII CHARACTERS		INDIVIDUAL VEHICLE FILING RECORD		Compulsory Insurance Reporting		
				RECORD SIZE		
				220		

ITEM NO.	FIELD POSITION	FIELD SIZE CHAR.	FIELD CHAR.	JUSTIFIED	FIELD LABEL	DESCRIPTION OR VALUE
1	1 - 30	30	X	Right / Space Filled	VIN	REQUIRED
2	31 - 35	5	N	Right	Ins-Comp-Code	REQUIRED
3	36	1	X		Transaction-Type	REQUIRED
4	37 - 66	30	X	Left	Ins-Policy-Nr	REQUIRED
5	67 - 74	8	N	Right	Termination-or-Change-or-Effective-Date (CCYYMMDD)	REQUIRED
6	75 - 79	5	N	Right	Serv-Agent-Code	REQUIRED
7	80 - 81	2	X		Lessee-or-Owner-State	REQUIRED
8	82 - 90	9	N	Right	Lessee-or-Owner-Identification-Number	REQUIRED
9	91 - 98	8	N	Right	Issue-Date (CCYYMMDD)	REQUIRED
10	99 - 132	34	X		Ins-Co-Usage	
11	133 - 184	52	X		Filler	SPACES
*** THE FOLLOWING FIELDS ARE OMV DATA RETURNED FOR RECORD TYPE = 1 ***						
12	185 - 192	8	N	Right	Return-Date	CCYYMMDD
13	193	1	X		Late-Flag	Y or N
14	194 - 218	25	X	Left	Edit-Error-Mask	
15	219	1	X	Left	Disposition	
16	220	1	N		Record-Type	1

J. Record Format—Fleet Filing Record

FIELD CHARACTERISTICS		RECORD NAME		SYSTEM		
A = ALPHABETIC X = ALPHANUMERIC N = NUMERIC (UNSIGNED) USAGE ALL ASCII CHARACTERS		FLEET FILING RECORD		Compulsory Insurance Reporting		
				RECORD SIZE	220	
ITEM NO.	FIELD POSITION	FIELD SIZE CHAR.	FIELD CHAR.	JUSTIFIED	FIELD LABEL	DESCRIPTION OR VALUE
1	1 - 5	5	N	Right	Ins-Comp-Code	REQUIRED
2	6	1	X		Transaction-Type	REQUIRED
3	7 - 36	30	X	Left	Ins-Policy-Nr	REQUIRED

4	37 - 44	8	N	Right	Termination-or-Change-or-Effective-Date (CCYYMMDD)	REQUIRED
5	45 - 49	5	N	Right	Serv-Agent-Code	REQUIRED
6	50 - 58	9	N	Right	Lessee-or-Owner-Federal-Tax-Identification-Number	REQUIRED
7	59 - 88	30	X	Left	Lessee-or-Owner-Name	REQUIRED
8	89 - 113	25	X	Left	Lessee-or-Owner-Address	REQUIRED
9	114 - 133	20	X	Left	Lessee-or-Owner-City-State	REQUIRED
10	134 - 138	5	N	Right	Lessee-or-Owner-Zip-Code	REQUIRED
11	139 - 142	4	N	Right	Number-of-Vehicles-in-Fleet	REQUIRED
12	143 - 150	8	N	Right	Issue-Date (CCYYMMDD)	REQUIRED
13	151 - 184	34	X		Ins-Co-Usage	
*** THE FOLLOWING FIELDS ARE OMV DATA RETURNED FOR RECORD TYPE = 4 ***						
14	185 - 192	8	N	Right	Return-Date	CCYYMMDD
15	193	1	X		Late-Flag	Y or N
16	194 - 218	25	X	Left	Edit-Error-Mask	
17	219	1	X	Left	Disposition	
18	220	1	N		Record-Type	4

K. Record Format—Trailer Record

FIELD CHARACTERISTICS		RECORD NAME TRAILER RECORD		SYSTEM Compulsory Insurance Reporting		
A = ALPHABETIC X = ALPHANUMERIC N = NUMERIC (UNSIGNED) USAGE ALL ASCII CHARACTERS				RECORD SIZE 220		
ITEM NO.	FIELD POSITION	FIELD SIZE CHAR.	FIELD CHAR.	JUSTIFIED	FIELD LABEL	DESCRIPTION OR VALUE
1	1 - 5	5	N	Right	Serv-Agent-Code	
2	6 - 13	8	N	Right	Date-Received	CCYYMMDD
3	14 - 21	8	N	Right	Date-Processed	CCYYMMDD
4	22 - 27	6	N	Right	Total-Number-of-Filing-Records	
5	28 - 33	6	N	Right	Total-Number-of-Disposition-D-Records	
6	34 - 39	6	N	Right	Total-Number-of-Disposition-E-Records	

7	40 - 45	6	N	Right	Total-Number-of-Disposition-H-Records	
8	46 - 51	6	N	Right	Total-Number-of-Disposition-I-Records	
9	52 - 57	6	N	Right	Total-Number-of-Disposition-P-Records	
10	58 - 63	6	N	Right	Total-Number-of-Disposition-R-Records	
11	64 - 69	6	N	Right	Total-Number-of-Disposition-S-Records	
12	70 - 75	6	N	Right	Total-Number-of-Disposition-U-Records	
13	76 - 81	6	N	Right	Total-Number-of-Late-Fillings	
14	82 - 219	138	X		Filler	SPACES
15	220	1	N		Record-Type	2

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004); amended LR 41:

§1757. Declaratory Orders and Rulings
[Formerly §1789]

A. Any person desiring a ruling on the applicability of R.S. 32:863.2, or any other statute, or the applicability or validity of any rule, to the reporting of initiation and any subsequent change in insurance coverage shall submit a written petition to the assistant secretary for the Office of Motor Vehicles. The written petition shall cite all constitutional provisions, statutes, ordinances, cases, and rules which are relevant to the issue presented or which the person wishes the assistant secretary to consider prior to rendering an order or ruling in connection with the petition. The petition shall be typed, printed or written legibly, and signed by the person seeking the ruling or order. The petition shall also contain the person's full printed name, the complete physical and mailing address of the person, and a daytime telephone number.

B. If the petition seeks an order or ruling on a report submitted to the Office of Motor Vehicles by a security provider, the person submitting the petition shall notify the security provider who submitted the report, if the person submitting the petition is not the security provider. Such notice shall be sent by certified mail, return receipt requested. In such case, the petition shall not be considered until proof of such notice has been submitted to the assistant secretary, or until the person petitioning for the order or ruling establishes that the security provider cannot be notified after a due and diligent effort. The notice shall include a copy of the petition submitted to the assistant secretary.

C. The assistant secretary may request the submission of legal memoranda to be considered in rendering any order or

ruling. The assistant secretary or his designee shall base the order or ruling on the documents submitted including the petition and legal memoranda. If the assistant secretary or his designee determines that the submission of evidence is necessary for a ruling, the matter may be referred to a hearing officer prior to the rendering of the order or ruling for the taking of such evidence.

D. Notice of the order or ruling shall be sent to the person submitting the petition as well as the security provider receiving notice of the petition at the mailing addresses provided in connection with the petition.

E. The assistant secretary may decline to render an order or ruling if the person submitting the petition has failed to comply with any requirement in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 24:1780 (September 1998), repromulgated LR 30:2856 (December 2004), LR 41:

§1758. Invalid Vehicle Type-Use

A. The type-use for a vehicle is in the "CLASS" field of the vehicle registration certificate. Below is a list of invalid "Type-Use" or "Class" of vehicles that are not to be reported to the department.

- 0109—Shriner Auto
- 0110—Grotto Auto
- 0111, 0112, 0113, 0114, 0115, 0116, 0117, 0118, 0147, 0148,
- 0149—Public Auto
- 0121, 0122—Consular Auto
- 0124, 0125—Governor's Staff Auto
- 0138—US Congressman
- 0139—US Senator
- 0205, 0236, 0241—Forest Truck
- 0209—Shriner Truck
- 0210—Grotto Truck
- 0211, 0212, 0213, 0214, 0215, 0216, 0217—Public Truck
- 0221, 0222—Consular Truck
- 0224, 0225—Governor's Staff Truck

0242, 0243, 0244, 0245, 0246—Farm Truck
 0252, 0253, 0254—Public Truck
 0262—Handicap Farm Truck
 0305, 0306, 0307, 0311, 0312, 0313, 0314, 0315,
 0316—Public Motorcycle
 0309—Shriner Motorcycle
 0310—Grotto Motorcycle
 0409—Shriner Bus
 0415, 0416, 0417, 0418, 0419, 0420, 0421, 0422, 0423, 0427,
 0428, 0429, 0466, 0467, 0468—Public Bus
 0601, 0602—House Trailer
 0701, 0722—Trailer
 0702, 0733—Boat Trailer
 0703—4 Year Trailer
 0704—Light Semi Trailer
 0705—Trailer Apportioned
 0706—Farm Semi Trailer
 0707, 0708, 0709, 0723, 0724, 0725—Public Perm Trailer
 0710, 0711, 0712—Public Boat Trailer
 0713, 0714, 0715—Public 4 Year Trailer
 0716, 0717, 0718—Public Light Semi Trailer
 0719, 0720, 0721—Public Plate Trailer
 0726—Shriner Trailer
 0727—Grotto Trailer
 0728—Appor Life trailer
 0729, 0730—Trailer Life
 0731, 0732—Trailer 4 Year
 0901, 0902, 0903, 0904, 0905—Off-Road Vehicle

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004), amended LR 41:

§1760. Identification Card Specifications

A. General Information

1. Pursuant to R.S. 32:863, which became effective July 1, 1985, all vehicles registered in the State of Louisiana must contain within the vehicle documentation indicating compliance with the Compulsory Motor Vehicle Liability Security Law. An identification card may be used in lieu of the actual policy as a means of showing evidence of liability insurance coverage.

2. The purpose of developing an approved identification card should be to provide a document to be used as proof of compliance with Louisiana’s compulsory insurance laws.

3. Those ID Cards, in conformance with the attached specifications, will be accepted as proof of liability insurance by law enforcement and by the Office of Motor Vehicles.

4. In order for the security provider to insure compliance with specification requirements, the security provider shall furnish the department with sample copies of its Louisiana Liability Insurance Identification Card. Mail sample ID cards to:

Department of Public Safety and Corrections
 Office of Motor Vehicles
 Compulsory Insurance Unit
 Post Office Box 64886
 Baton Rouge, LA 70896-4886

or

Fax copy to (225) 922-0158
 Attention: Supervisor

5. For questions regarding implementation, please call the Compulsory Insurance Unit at (225) 925-7285.

B. Louisiana Identification Card Specifications

1. Size of document need not be uniform.

2. Card should be a one-part form on at least 20 lb. white paper stock.

3. The following general information must be designated on the card in either bold print or contrasting color:

a. Front

i. Louisiana Auto Insurance Identification Card

ii. An insurer authorized to transact business in Louisiana has issued the Motor Vehicle Policy identified hereon. The coverage provided by this policy meets the minimum liability insurance limits prescribed by law.

(a). This wording is necessary to meet requirements without having to specify the actual insurance limits on all vehicles (vehicles under or over 20,000 lbs.).

iii. This card must be carried in the vehicle at all times as evidence of liability insurance

b. Reverse

“IMPORTANT NOTICE

La. R.S. 32:863.1 requires that an operator of a motor vehicle produce upon demand by a law enforcement officer documentation of motor vehicle security which is required to be maintained within the vehicle at all times.

Failure to comply may result in fines, revocation of registration privileges and block against the renewal or issuance of a driver’s license.”

4. Specific information required on the Identification Card is as follows:

a. Front

i. The name, address and NAIC number of the insurance company.

ii. Name of insured, policy number, effective date and expiration date. When a new vehicle is added to an existing policy, make sure the effective date used is the date the vehicle was added to the policy, not the issue date of the original policy.

iii. Vehicle Description: the year may be shown as two digits and the make may be abbreviated. The full VIN number must be shown. Only when the insurer does not have the VIN information under a fleet policy, is the word “FLEET” to be entered. The Federal Tax identification number of the listed insured must be provided when “FLEET” is used.

b. Front or Back

i. Any excluded driver’s on the policy must be listed.

ii. The excluded driver’s date of birth and/or operator’s license number (optional)

iii. The insurance agent’s name, address and telephone number**

(a). In accordance with Act 527 (SB882) R.S. 32:397(A), the insured will be required to furnish proof of insurance to law enforcement at the time of an accident.

5. The certificate should be provided to each liability policy holder at least annually or at each renewal.

6. Other items may be included at the discretion of the insurer such as company logo or any other message(s) including claim locations, what to do in the event of an accident, etc., on the reverse side of the card.

C. Examples of Louisiana Identification Card

LOUISIANA AUTO INSURANCE IDENTIFICATION CARD		
An insurer authorized to transact business in Louisiana has issued the Motor Vehicle Policy identified hereon. The coverage provided by this policy meets the minimum liability insurance limits prescribed by law.		
NAIC NUMBER	COMPANY	
POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE
VEHICLE DESCRIPTION		
YEAR	MAKE/MODEL	VEHICLE IDENTIFICATION NUMBER
INSURED		
THIS CARD MUST BE IN THE VEHICLE AT ALL TIMES AS EVIDENCE OF INSURANCE		

IMPORTANT NOTICE
La. R.S. 32:863.1 requires that an operator of a motor vehicle produce upon demand by a law enforcement officer documentation of motor vehicle security which is required to be maintained within the vehicle at all times.
Failure to comply may result in fines, revocation of registration privileges and block against the renewal or issuance of a driver's license.
INSURANCE AGENT:
EXCLUDED DRIVERS:

D. Sample Identification Card with Individual Vehicle Information

LOUISIANA AUTO INSURANCE IDENTIFICATION CARD		
An insurer authorized to transact business in Louisiana has issued the Motor Vehicle Policy identified hereon. The coverage provided by this policy meets the minimum liability insurance limits prescribed by law.		
NAIC NUMBER	COMPANY	
12345	Compulsory Insurance Company 1234 Liability Lane Security, LA 10000	
POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE
ABC 12345	01/01/2010	01/01/2011
VEHICLE DESCRIPTION		
YEAR	MAKE/MODEL	VEHICLE IDENTIFICATION NUMBER
2005	Chev/Cam	1GTCE1456PB123456
INSURED		
John Doe 203 Doe Street Baton Rouge, LA 70895		
THIS CARD MUST BE IN THE VEHICLE AT ALL TIMES AS EVIDENCE OF INSURANCE		

IMPORTANT NOTICE
La. R.S. 32:863.1 requires that an operator of a motor vehicle produce upon demand by a law enforcement officer documentation of motor vehicle security which is required to be maintained within the vehicle at all times.

Failure to comply may result in fines, revocation of registration privileges and block against the renewal or issuance of a driver's license.
INSURANCE AGENT: All Day Insurance Agency 1000 Anywhere Street Baton Rouge, LA 70806 Phone # (225) 123-4567
EXCLUDED DRIVERS: Johnny Doe

E. Sample Identification Card with Fleet Information

LOUISIANA AUTO INSURANCE IDENTIFICATION CARD		
An insurer authorized to transact business in Louisiana has issued the Motor Vehicle Policy identified hereon. The coverage provided by this policy meets the minimum liability insurance limits prescribed by law.		
NAIC NUMBER	COMPANY	
12345	Compulsory Insurance Company 1234 Liability Lane Security, LA 10000	
POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE
ABC 12345	01/01/2010	01/01/2011
VEHICLE DESCRIPTION		
YEAR	MAKE/MODEL	VEHICLE IDENTIFICATION NUMBER
		FLEET – FEDERAL TAX ID # 720000000
INSURED		
John Doe Trucking, Inc. 203 Doe Street Baton Rouge, LA 70895		
THIS CARD MUST BE IN THE VEHICLE AT ALL TIMES AS EVIDENCE OF INSURANCE		

IMPORTANT NOTICE
La. R.S. 32:863.1 requires that an operator of a motor vehicle produce upon demand by a law enforcement officer documentation of motor vehicle security which is required to be maintained within the vehicle at all times.
Failure to comply may result in fines, revocation of registration privileges and block against the renewal or issuance of a driver's license.
INSURANCE AGENT: All Day Insurance Agency 1000 Anywhere Street Baton Rouge, LA 70806 Phone # (225) 123-4567
EXCLUDED DRIVERS: N/A

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004), amended LR 41:

§1762. Proof of Liability Security

A. In accordance with Act 423 (HB1366) R.S. 32:862(B)(H), licensed drivers and motor vehicle owners will be required to show proof of liability coverage at the time of vehicle registration, renewal of license plate and at the time of initial application, renewal or change of address/endorsement for a driver's license. Acceptable proof of insurance will be in the form of one of the following.

1. For vehicles with a gross vehicle weight of 20,000 pounds or under:

a. proof that a liability insurance policy providing at least \$15,000/\$30,000 bodily injury and \$25,000 property damage as provided in R.S. 32:900(B) was issued. (Copy of

insurance identification card, copy of insurance policy or copy of declaration page of insurance policy); or

b. proof that an approved motor vehicle liability bond was issued by a surety or insurance company in the amount of \$30,000; or

c. proof that a certificate was issued from the state treasurer stating that cash or securities of \$55,000 was on deposit with the state treasurer; or

d. proof that a Louisiana certificate of self-insurance was issued under R.S. 32:1042.

2. For vehicles with a gross vehicle weight of 20,001-50,000 pounds:

a. proof that a liability insurance policy providing at least \$25,000/\$50,000 bodily injury and \$25,000 property damage as provided in R.S. 32:900(B) was issued. (Copy of insurance policy or copy of declaration page of insurance policy); or

b. proof that a Louisiana certificate of self-insurance was issued under R.S. 32:1042 (Act 34 of the First Extraordinary Special Session of 1996); or

c. proof of single state registration (current form RS-3); or

d. proof of Public Service Commission authority (current intra-state ID cab card); or

e. proof that a certificate of self-insurance was issued by the Interstate Commerce Commission (ICC) under R.S. 32:900(M)(3).

3. For vehicles with a gross vehicle weight over 50,001 pounds:

a. proof that a liability insurance policy providing at least \$100,000/\$300,000 bodily injury and \$25,000 property damage or combined single limit of \$300,000 as provided in R.S. 32:900(B) was issued. (Copy of insurance policy or copy of declaration page of insurance policy); or

b. proof that a Louisiana certificate of self-insurance was issued under R.S. 32:1042 (Act 34 of the first extraordinary special session of 1996); or

c. proof of single state registration (current form RS-3); or

d. proof of Public Service Commission authority (current intra-state ID cab card); or

e. proof a certificate of self-insurance was issued by the Interstate Commerce Commission (ICC) under R.S. 32:900(M)(3).

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2844 (December 2004), amended LR 41:

§1764. Declaratory Orders and Rulings

[Former §1789]

A. Any person desiring a ruling on the applicability of R.S. 32:863.2, or any other statute, or the applicability or validity of any rule, to the reporting of initiation and any subsequent change in insurance coverage shall submit a written petition to the assistant secretary for the Office of Motor Vehicles. The written petition shall cite all constitutional provisions, statutes, ordinances, cases, and rules which are relevant to the issue presented or which the person wishes the assistant secretary to consider prior to rendering an order or ruling in connection with the petition. The petition shall be typed, printed or written legibly, and signed by the person seeking the ruling or order. The petition

shall also contain the person's full printed name, the complete physical and mailing address of the person, and a daytime telephone number.

B. If the petition seeks an order or ruling on a report submitted to the Office of Motor Vehicles by a security provider, the person submitting the petition shall notify the security provider who submitted the report, if the person submitting the petition is not the security provider. Such notice shall be sent by certified mail, return receipt requested. In such case, the petition shall not be considered until proof of such notice has been submitted to the assistant secretary, or until the person petitioning for the order or ruling establishes that the security provider cannot be notified after a due and diligent effort. The notice shall include a copy of the petition submitted to the assistant secretary.

C. The assistant secretary may request the submission of legal memoranda to be considered in rendering any order or ruling. The assistant secretary or his designee shall base the order or ruling on the documents submitted including the petition and legal memoranda. If the assistant secretary or his designee determines that the submission of evidence is necessary for a ruling, the matter may be referred to a hearing officer prior to the rendering of the order or ruling for the taking of such evidence.

D. Notice of the order or ruling shall be sent to the person submitting the petition as well as the security provider receiving notice of the petition at the mailing addresses provided in connection with the petition.

E. The assistant secretary may decline to render an order or ruling if the person submitting the petition has failed to comply with any requirement in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 24:1780 (September 1998), repromulgated LR 30:2856 (December 2004), repromulgated LR 41:

Subchapter C. Compulsory Insurance Enforcement

§1766. Introduction

A. The Louisiana Legislature enacted law R.S. 32:863.2(F) requiring the Louisiana Department of Public Safety (DPS) to create an online insurance verification system. DPS (Louisiana State Police and the Office of Motor Vehicles) is implementing the Louisiana insurance verification system (LAIVS) in order to meet the law's requirements and provide the Louisiana State Police (LSP), Office of Motor Vehicles (OMV), State Courts, Law Enforcement Agencies, and other authorized users with the ability to perform real-time insurance verification. LAIVS will utilize the Insurance Industry Committee on Motor Vehicle Administration (ICMVA) standards for insurance provider reporting.

B. DPS has partnered with a contracted vendor, MV Solutions Inc., to implement LAIVS. This new system will interface with various state computer systems and networks.

C. Louisiana (LA) licensed insurance providers will be required to make motor vehicle liability insurance information available to LAIVS in the manner defined below for vehicles registered in LA.

D. Insurance providers are required to continue reporting notification of initiation, termination, or modification of liability security to the current LA insurance reporting

system. The state intends to replace the current reporting system after successful implementation of LAIVS in a subsequent phase of this project that will be part of a separate procurement solicitation from prospective contractors.

E. LAIVS reporting requirements are summarized below.

1. Insurance providers covering 500 or more vehicles registered in LA must establish a web service that will allow LAIVS instant direct verification of insurance.

a. The web services shall be in compliance with the specifications and standards of the Insurance Industry Committee on Motor Vehicle Administration (IICMVA).

b. Insurance providers issuing commercial policies who capture the VINs shall comply with the web service requirement unless they have been granted an exemption by the commissioner of OMV.

2. All insurance providers writing private passenger and commercial motor vehicle policies in LA are required to report specified policy, vehicle, and customer information [referred to as the Book of Business (BOB)] to LAIVS.

a. Insurance providers must submit BOB data to LAIVS at least once a calendar month. Insurance providers who are not hosting a web service or whose web service do not support VIN broadcasting must provide BOB data on a weekly basis. This data will be used by LAIVS to route instant or real-time verification queries.

b. Unless an insurance provider issues coverage for less than 500 vehicles registered in LA, the insurance provider must submit BOB data to LAIVS via the file transfer protocol (FTP) process outlined in this guide. Insurance providers issuing coverage for less than 500 vehicles can either FTP the BOB file or utilize the LAIVS website for BOB reporting.

c. The vehicle identification number (VIN) will not be required for fleet policies. A fleet policy is a policy insuring a business with a fleet of five or more vehicles registered in LA for which VIN information is not maintained on each vehicle. However, if the insurance provider does maintain the VIN of the vehicles within the fleet, the VINs must be reported in the book of business file.

F. Insurance Provider Compliance Timeline

1. By September 21, 2015—insurance providers register on the LAIVS website.

2. By November 20, 2015—insurance providers submit a test BOB file to LAIVS and begin web services testing. Insurance providers with existing web services active in other jurisdictions can use their production web services for testing

3. By February 23, 2016—insurance providers move to a production environment, including BOB data submission and web services (if applicable). Insurance providers are encouraged to move to production earlier as state users will begin using LAIVS for insurance verification before this deadline.

G. As previously stated, insurance providers are required to continue reporting notification of initiation, termination, or modification of liability security to the current LA insurance reporting system. The state intends to replace the current reporting system after successful implementation of LAIVS in a subsequent phase of this project that will be part

of a separate procurement solicitation from prospective contractors.

H. This guide is posted on the LAIVS website. Go to www.LAIVS.org, click on the HELP link, and then on Help For Insurance Providers. If you have any questions, please contact the LAIVS help desk at support@LAIVS.org.

I. Insurance providers are responsible for reading and complying with this entire document and reviewing additional information posted on the www.LAIVS.org website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1767. Book of Business Reporting

A. Insurance providers must submit book of business (BOB) files to LAIVS by the seventh calendar day of each month. Insurance providers whose web services do not support VIN broadcasting or are not hosting a web service must provide BOB data on a weekly basis. Insurers providing weekly BOB data can submit the data on any day of the week including the weekend. Insurance providers that issue coverage for less than 500 vehicles in Louisiana shall either submit BOB files via FTP or report BOB data using the LAIVS website. Follow the guidelines and procedures explained in the sections below when providing the BOB files to LAIVS.

B. BOB Data to Be Reported. Report the following information when submitting the BOB files:

1. all active LA motor vehicle insurance policies with the minimum liability coverage required by the state of Louisiana and the associated vehicles and customers;

2. both private passenger and commercial motor vehicle insurance policies shall be reported. The VIN is not required for fleet policies. A fleet policy is a policy insuring a business with a fleet of five or more vehicles registered in LA for which VIN information is not maintained on each vehicle. However, if the insurance provider does maintain the VIN of the vehicles within the fleet, the VINs must be reported in the book of business file;

3. the vehicle types that should be reported are provided in Appendix C.

C. BOB File Structure. The BOB file structure is based upon Version 1.1 of the Insurance Data Transfer Guide published by the IICMVA on August 23, 2011. The BOB file is a text file with rows of fixed length. All rows will be 300 characters long with spaces used as filler. Follow each row with a carriage return line feed character (Hexadecimal '0D 0A'). Submit a separate file for each NAIC number.

1. File Name. The file name should include the following fields.

a. NAIC Number: Insurance provider's NAIC Number

b. File Creation Date: Date file was created in the YYYYMMDD format

c. Environment: "P"—Production; "T"—Test

d. Extension: File extension such as "pgp", "asc", "txt" or any other 3 character file extension

e. File Name format should be in the *NAIC_Date_Environment.extension* format. For example: 12345_20110815_P.pgp

2. Detail Rows. The detail rows show the policy data being submitted by the insurance provider. Generate one record per customer, vehicle, and policy combination. For example, if policy number 12345 is associated with customers Jane and John Doe on a 2004 Jeep and a 2005 GMC, then four records with the following combinations should be created.

a. Jane Doe, 2004 Jeep, policy 12345

b. Jane Doe, 2005 GMC, policy 12345
 c. John Doe, 2004 Jeep, policy 12345
 d. John Doe, 2005 GMC, policy 12345
 e. Each field's length is specified in the table below with any unused length filled by trailing spaces. Any fields for which a value is not being provided should be filled with spaces. Provide the following fields in each row.

Field Id	Field Name	Length	Begin	End	Type (AN –Alpha numeric N- Numeric)	Mandatory/ Optional	Description
1	POLICY TYPE	2	1	2	AN	M	'VS' = Vehicle Specific 'NS' = Non Vehicle Specific (Fleet Policies)
2	NAIC	5	3	7	N	M	NAIC Code
3	POLICY NUMBER	30	8	37	AN	M	Policy Number
4	EFFECTIVE DATE	8	38	45	N	M	Effective Date – YYYYMMDD format Date coverage was added for the vehicle. There should not be any time out of force (lapse of coverage) between the Effective Date and the transmission date. If the vehicle had any time out of force, then the effective date that coverage was resumed or reinstated should be reported.
5	VIN	25	46	70	AN	O	VIN (optional for non-vehicle specific fleet policy)
6	LAST NAME or ORGANIZATION	40	71	110	AN	M	
7	PREFIX NAME ABBR	3	111	113	AN	O	
8	MIDDLE NAME	20	114	133	AN	O	
9	FIRST NAME	40	134	173	AN	O	Mandatory if customer is an individual
10	SUFFIX NAME	3	174	176	AN	O	Abbreviated Name Suffix (JR, SR, etc.)
11	FEIN	9	177	185	AN	O	
12	ADDRESS	50	186	235	AN	M	
13	CITY	35	236	270	AN	M	
14	STATE	2	271	272	AN	M	
15	ZIP	5	273	277	N	M	
16	COMMERCIAL INDICATOR	1	278	278	AN	O	"Y" for commercial policies
17	FILLER	1	279	279	AN	O	
18	POLICY EXPIRATION DATE	8	280	287	N	O	Future expiration/renewal date of the current policy term. Format is YYYYMMDD.
19	FILLER	13	288	300	AN	M	Space Filled

3. Trailer Row. Each file should have one trailer row with the following fields.

Field Name	Length	Begin	End	Type	Mandatory/ Optional	Description
TYPE	2	1	2	AN	M	TR' = Trailer
RECORD COUNT	12	3	14	N	M	Record count not including Trailer Record
PROCESS DATE	8	15	22	N	M	Date the file was created – YYYYMMDD Format
FILLER	278	23	300	AN	M	Space Filled

D. BOB File Submission. Each insurance provider will be assigned an FTP account (see Section 2.5). There will be two folders under each FTP account. Place all BOB files into the BOB_Inbound folder. All return files created by LAIVS in response to the BOB files will be placed in the BOB_Outbound folder.

E. BOB Return Files Generated for Insurance Providers. This section describes the types of files that may be generated by LAIVS and placed in the BOB_Outbound folder of the insurance provider. These files will inform

insurance providers if their files were successfully processed or if any errors were encountered in the processing. For each BOB file submitted by the insurance provider, at least one of the following files will be generated by LAIVS:

1. OK File. If there are no errors in the BOB file submitted by the insurance provider, an OK file will be generated. The OK file name will be named `OK_NAIC_DateTimeStamp.pgp` (e.g. `OK_12345_20110806121501.pgp`).

2. Decryption Error File. This file will be generated if a PGP decryption error occurs. Decryption errors can happen for the following reasons.

a. File sent by insurance provider was not encrypted.

b. File sent by insurance provider was improperly encrypted.

c. File sent by insurance provider was encrypted using the wrong PGP key.

d. Decryption error file will be identified based on the file name prefix DE. The file will be named *DE_NAIC_DatetimeStamp.pgp* (e.g. *DE_12345_20110806121501.pgp*).

3. Reject File. This file will be generated if LAIVS cannot read the file or if the file is improperly formatted and the whole file is being rejected. The file may be rejected for the following reasons.

a. File is not formatted properly.

b. Trailer has a non-zero record count but detail records of the file are missing.

c. Length of each record (line) is not up to the length specified in this guide.

d. End of a record missing carriage return and line feed (Hexadecimal '0D 0A').

e. The reject file will contain the description of the error at the top followed by the contents of the file.

f. The reject file can be identified based on the file name prefix REJ. File will be named *REJ_NAIC_DatetimeStamp* (e.g. *REJ_12345_20110806121501.pgp*).

4. Row Error File. Row error files are generated when the overall file format sent by the insurance provider is okay but some of the rows have errors including:

a. mandatory fields missing;

b. invalid field formats;

c. the row error file will contain only the records that are in error. The remaining records sent with the original file will be processed by LAIVS and will not appear in the file. Each error record will have the original row sent by the insurance provider followed by a 3 digit Error Code. The format of the Error Code will be E followed by the Field ID of the invalid/missing field. For example, the Error Code for a row with an invalid NAIC number will be "E02". A complete list of Error Codes is provided in Appendix D;

d. the Row Error file can be identified based on the file name prefix ERR. File will be named *ERR_NAIC_DatetimeStamp* (e.g. *ERR_12345_20110806121501.pgp*);

5. VIN No-Match File. The VIN No-Match files are generated if any of the VINs submitted by the insurance provider do not match VINs of vehicles registered in LA. The VIN No-Match file will include all the records where the VIN did not match. Each record will have the original row sent by the insurance provider followed by "E05", the 3 digit Error Code indicating VIN mismatch. VIN No-Match files are sent to insurance providers for informational purposes and insurance providers are not required to take action based on these files.

a. The VIN No-Match file can be identified based on the file name prefix VIN. File will be named *VIN_NAIC_DatetimeStamp* (e.g. *VIN_12345_20110806121501.pgp*).

F. FTP Accounts and PGP Encryption. Insurance providers must send text files to LAIVS using File Transfer

Protocol (FTP). FTP accounts will be created for each insurance provider after registering with LAIVS. If the insurance provider prefers, the same FTP account can be shared by providers with different NAIC numbers that are under the same insurance group. Login information and the IP addresses of the FTP servers will be provided after registration.

1. Each FTP account will have the following folders:

a. BOB_Inbound;

b. BOB_Outbound.

2. All files exchanged between LAIVS and insurance providers will be encrypted by the Pretty Good Privacy (PGP) digital data encryption program. Public PGP keys will be exchanged with the LAIVS Help Desk prior to exchanging insurance data. In addition, insurance providers will have the option to use SFTP (Secure File Transfer Protocol using SSH) instead of FTP for transmission layer security.

G. BOB File Testing Process. Before testing begins, each insurance provider participating in LAIVS must register on the LAIVS website as described in Section 5. After completing registration, insurance providers will be contacted by the LAIVS team to schedule a conference call to discuss the testing process and address any questions about the LAIVS reporting requirements. FTP User IDs and passwords will be provided and public PGP keys will be exchanged. The testing process includes the following:

1. Connectivity Testing. The insurance provider should be able to connect to the designated LAIVS FTP server, log in to the insurance provider's FTP account, and transfer files to the appropriate folders. The insurance provider should be able to retrieve LAIVS return files.

2. Decryption. LAIVS should be able to successfully decrypt files. The insurance provider should be able to successfully decrypt LAIVS return files.

3. File Format. The insurance provider files should be formatted according to LAIVS requirements.

4. File Content. The insurance provider file should contain valid test data and the data elements should meet the LAIVS rules. During testing, it is not necessary to provide production data (in force policies).

5. Insurance providers must pass the above tests before submitting production data. The LAIVS team will work with insurance providers and provide information to assist in resolution of any errors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1768. Insurance Provider Web Services

A. All insurance providers, except those granted an exemption, are required to implement web services capable of correctly verifying the existence of mandatory insurance for vehicles registered in LA. Insurance providers covering less than 500 vehicles registered in LA are encouraged, but are not required, to provide a web service.

B. Web Service Structure. The LAIVS Online Verification client is based upon the model developed by the IICMVA that allows a jurisdiction to use web services hosted by insurance providers to verify insurance. This section describes the overall structure of the web services to be hosted by the insurance providers.

1. Web Services Description Language (WSDL) File. A WSDL file is an XML file that describes the public interface to a web service. The IICMVA has created WSDL files for Java, .Net, and Universal web service implementations. To make the verification process as fast as possible, LAIVS uses these WSDL files and does not attempt to read the WSDL file at each web service every time a verification request is initiated. LAIVS manages the endpoints, which are uniform resource locators (URLs), from a local configuration file.

2. Schema. An XML schema describes the structure of an XML message. LAIVS currently supports the ANSI ASC X12 Insurance Committee's XML schema for online insurance verification. Case is not specified in the schema. If an insurance provider has particular requirements for upper or lower case, the message payload must be converted to the required case. Also, the policy number must be converted to the required format.

3. Extensible Markup Language (XML) Messages. The XML messages for the insurance verification request and response are derived from the schema. Appendix A contains a sample verification request message and a sample verification response message.

4. Simple Object Access Protocol (SOAP) SOAP is an XML based protocol that is used by web services to wrap around the XML messages making them platform and language independent. SOAP 1.1 is required.

5. Hypertext Transfer Protocol (HTTP) over Transmission Control Protocol/Internet Protocol (TCP/IP). The XML messages will be transported over the internet via HTTP. Verification requests will utilize HTTP 1.1 and it is strongly suggested that it be used for the verification responses as well.

6. Security. The XML messages will be encrypted via the Secure Sockets Layer (SSL). LAIVS will maintain Class 3 X.509 certificates identifying both the test and production environments. The certificate will be presented in each connection handshake so that the insurance provider can authenticate the client.

C. Expected Level of Service

1. Insurance providers' web services are required to respond to verification requests on a 24/7/365 basis. Although a reasonable amount of downtime to maintain and upgrade systems may occur, the web service availability, measured on a monthly basis, shall be at least 99 percent.

2. Scheduled downtime must be reported via e-mail to support@LAIVS.org as early as possible, describing the reason for the downtime, the time the web service will become unavailable, and the time it is expected to become available again.

3. Unscheduled downtime must be reported via e-mail to support@LAIVS.org immediately, describing the reason for the downtime, the time the web service became unavailable, and the estimated time it will become available again.

4. Each online LAIVS transaction should take no more than five seconds from the time that the verification request message is initiated by the user's system until the response reaches the user's system. In order to achieve the overall five second response time, each insurance provider should design its web service to provide a response within two seconds of receipt of an inquiry. Contributing factors to

slow responses outside the control of the insurance providers, such as Internet response time, will be taken into account. Responses not received in a timely manner will be logged and used for evaluating the insurance provider's web services performance.

5. Accuracy is critical to the success of the program. Therefore, each insurance provider's web service must provide the correct response to an inquiry. Each web service will be monitored and tested for accurate responses, including testing for false confirmations.

D. The Verification Request and Response

1. LAIVS supports the current and previous versions of the IICMVA specifications and plans to include future versions as they are issued. Prior to implementation of a schema, a WSDL created from the schema must be tested and approved.

2. The Verification Request

a. The verification request is sent to the appropriate insurance provider by LAIVS in the XML message format that is valid for the schema employed by the insurance provider's web service. Verification that the request is from an authorized entity can be established from the certificate that LAIVS will present when the connection is initiated.

b. The following data elements will be in the verification request message:

i. tracking/reference number (ties the request to the response);

ii. National Association of Insurance Commissioners (NAIC) code (identifies insurance provider);

iii. vehicle identification number (VIN);

iv. policy number ("UNKNOWN" will be provided, if not available);

v. verification date. The verification date may be the current date or a date in the past. Insurance providers are required to maintain at least six months history. When a data element is required by the schema, if that data element is not available, LAIVS will send the following default value:

(a). "UNKNOWN" in any mandatory field where text is expected;

(b). zeroes in any mandatory field where numbers are expected.

3. The Verification Response

a. For each verification request sent by LAIVS, a verification response is issued by the insurance provider's web service. Because of front end edits, LAIVS will not send inquiries that would result in a response from the insurance provider that the request was invalid.

b. If minimum financial responsibility coverage is present and the policy is active on the requested verification date, the insurance provider responds with the following coverage confirmation result: CONFIRMED.

c. If minimum financial responsibility coverage is not present or the policy is not active on the requested verification date, the insurance provider responds with the following coverage confirmation result: UNCONFIRMED.

d. The required data element in a verification response is:

i. ResponseCode.

e. We also recommend including the following data elements. However, these data elements are not mandatory.

i. UnconfirmedReasonCode

- ii. TrackingNumber (return the number received in the verification request)
- iii. NAIC
- iv. VerificationDate
- v. UniqueKey (policy number)
- vi. PolicyState

E. Web Service Testing

1. Before testing begins, each insurance provider will have to register on the LAIVS website as described in Section 5. After registration is complete, the insurance provider will be contacted by the LAIVS team to schedule a conference call to discuss the testing process and address any questions about the LAIVS requirements. The following information will be collected during the call:

- a. NAIC codes and the corresponding names of the underwriting insurance providers that will be responding to verification requests through the web service;
- b. the web service URL(s);
- c. a time frame during which insurance providers would like to conduct the testing.

2. Following the call, the insurance provider will be sent the following:

- a. the SSL certificates that identify the LAIVS web service client;
- b. the IP addresses that identify the source of the verification requests.

3. Although it is not required, the insurance provider can also send its SSL certificate for installation in the LAIVS trust store.

4. The testing will consist of the following steps.

a. Basic Connectivity Test. Connectivity between endpoints is tested via “ping” to ensure that endpoints are reachable.

b. Test ability to send and receive messages. Test verification requests and responses formatted in XML and wrapped in SOAP are exchanged.

c. Testing with security. The SSL encryption and authentication via the X.509 certificates will be enabled. Testing will be done to ensure that the functionality is not impacted. To properly authenticate the certificate from the jurisdiction, each insurance provider must install the public key from the jurisdiction’s certificate and the root certificate from the issuing certificate authority.

d. Test Cases and Data. LAIVS will run the Insurance provider’s Web service through a set of test cases. If required, the insurance provider will provide the data necessary for these test cases. After all the above testing has been completed, the insurance provider can make their production Web Services available to LAIVS for insurance verification.

F. VIN Broadcasting

1. If the VIN in the verification request message matches an insured vehicle but the policy number in the request does not match the insurance policy number, then the insurance provider’s web service should be able to indicate that the vehicle is covered (this is known as “VIN Broadcasting” or “Unknown Carrier Request”). The insurance provider can indicate that the vehicle is covered in one of the following ways:

- a. Returning a value of “UNCONFIRMED” in the ResponseCode field and a value of “10” or “VIN3” in the

UnconfirmedReasonCode field of the CoverageResponse document.

- b. Returning a value of “CONFIRMED” in the ResponseCode field of the CoverageResponse document.

2. It is recommended that insurance provider web services support VIN broadcasting. If an insurance provider web service does not support VIN broadcasting, then they are required to provide BOB data on a weekly basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1770. Reporting By Smaller Insurance Providers

A. Smaller insurance providers providing coverage for less than 500 vehicles are not required to host insurance verification web services and report BOB files via FTP. If the smaller insurance providers are not reporting BOB files by FTP, these providers shall perform a one-time entry of all policies via the LAIVS website. After the initial entry, these insurance providers will only be required to update their policies on the LAIVS website whenever a policy is added, modified or cancelled/expired. If there is no update to their policies, these insurance providers are required to indicate this on the LAIVS website every week.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1772. Registration Process

A. Insurance providers must register on the LAIVS website before testing with LAIVS. The LAIVS website can be accessed at <https://www.LAIVS.org>. Cookies should be enabled for the website to properly function after the user has logged in. The LAIVS website is used for user registration, account management, reporting, user management, and providing help to insurance providers.

B. Insurance Provider Registration. To register, go to the LAIVS website home page and click on the “Register” link in the menu on the left side. Self-registration is only available to insurance providers that are licensed in LA. Please follow the instructions below.

1. Fill in all the insurance provider information and functional contact details.
2. Fill in the technical contact details.
3. Fill in the compliance contact details. The compliance contact is used to verify insurance by the LAIVS help desk.
4. Provide the password in the web login section.
5. Provide a secret question and answer which will be used with the forgot password functionality.

C. After the insurance provider submits the registration request, the web account is created and the LAIVS team will review and verify it. If the registration requirements are not met, the contact information submitted during registration will be used to notify the registrant and collect any missing/incorrect information. Once verification is complete, the insurance provider will be contacted by a LAIVS representative to start the testing process.

D. Accessing Help. The LAIVS website help function is available to users at all times and does not require the user to log in to the website. In order to get help, click on the “help” link from the left menu on any screen. The following information is available through the help function:

1. Users can download the latest version of the LAIVS Implementation Guide that provides detailed information on interacting with LAIVS.

2. A frequently asked questions section will be populated based on queries that the LAIVS help desk receives most often.

3. If these sources listed above are not sufficient, click on the “contact” link to write an email to the LAIVS help desk. The LAIVS help desk can be contacted directly at support@LAIVS.org.

E. Login for Registered and Approved Insurance Provider Users. The insurance provider must be registered with the LAIVS website and the account must be activated before a user can log in. To log in, enter the user name and password on the LAIVS website home page and then click the login button.

F. Insurance Provider Profile Management. Once logged in, the user can click on the Account Information link to access the provider profile information. The user can change the address, contact, and password information.

G. Insurance Provider Reports. This section will provide reports that will allow the insurance providers to determine the processing status of the files that were submitted. Users will be able to sort and search by the various fields in the reports, and will also be able to export data to Microsoft Excel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1774. Support

A. Insurance providers with questions about LAIVS or needing any clarification about information provided in this guide should send an email to support@LAIVS.org.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1776. Appendix A—Sample Verification Request and Response Messages

A. Please Note. The sample request and response messages included in this guide are for illustrative purposes and do not necessarily reflect the latest version. Prior to implementation of a schema, a WSDL created from the IICMVA schema must be tested and approved.

1. Sample Verification Request Message

```
<?xml version="1.0" encoding="UTF-8"?>
<soapenv:Envelope
xmlns:soapenv="http://schemas.xmlsoap.org/soap/envelope/"
xmlns:xsd="http://www.w3.org/2001/XMLSchema"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
  <soapenv:Body>
    <CoverageRequest
xmlns="http://www.iicmva.com/CoverageVerification/"
PublicationVersion="00200809" PublicationDate="2008-11-05">
      <RequestorInformation>
        <Organization>
          <Name>LAIVS</Name>
        </Organization>
        <ReasonDetails>
          <ReasonCode>BIVER</ReasonCode>
          <TrackingNumber>CTTRK-150219-144041-4-31-101-85-
```

```
1</TrackingNumber>
        </ReasonDetails>
      </RequestorInformation>
    </Detail>
  </PolicyInformation>
  <OrganizationDetails>
    <NAIC>12345</NAIC>
  </OrganizationDetails>
  <PolicyDetails>
    <VerificationDate>2015-02-19T00:00:00.000</VerificationDate>
    <PolicyKey>UNKNOWN</PolicyKey>
    <PolicyState>CT</PolicyState>
  </PolicyDetails>
</PolicyInformation>
<VehicleInformation>
  <VehicleDetails>
    <VIN>VINTEST123</VIN>
  </VehicleDetails>
</VehicleInformation>
</Detail>
</CoverageRequest>
</soapenv:Body>
</soapenv:Envelope>
```

2. Sample Verification Response Message

```
<?xml version="1.0" encoding="UTF-8"?>
<SOAP-ENV:Envelope
xmlns:xsd="http://www.w3.org/2001/XMLSchema" xmlns:SOAP-
ENV="http://schemas.xmlsoap.org/soap/envelope/"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns:SOAP-
ENC="http://schemas.xmlsoap.org/soap/encoding/">
  <SOAP-ENV:Body>
    <CoverageResponseDocument PublicationVersion="00200809"
PublicationDate="2008-11-05"
xmlns="http://www.iicmva.com/CoverageVerification/">
      <RequestorInformation>
        <!-- this section can be echoed from the request -->
      </RequestorInformation>
      <Organization>
        <Name>LAIVS</Name>
      </Organization>
      <ReasonDetails>
        <ReasonCode>BIVER</ReasonCode>
        <TrackingNumber>CTTRK-150219-144041-4-31-101-85-
1</TrackingNumber>
      </ReasonDetails>
    </RequestorInformation>
  </Detail>
  <PolicyInformation>
    <CoverageStatus>
      <ResponseDetails>
        <ResponseCode>Unconfirmed</ResponseCode>
        <UnconfirmedReasonCode>VIN1</UnconfirmedReasonCode>
      </ResponseDetails>
    </CoverageStatus>
    <OrganizationDetails>
      <NAIC>12345</NAIC>
    </OrganizationDetails>
    <!-- this can be echoed from the request or provide the actual NAIC that
has evidence of coverage -->
  </PolicyInformation>
  <PolicyDetails>
    <!-- this section can be echoed from the request -->
    <VerificationDate>2015-02-19T00:00:00.000</VerificationDate>
    <PolicyKey>UNKNOWN</PolicyKey>
    <PolicyState>CT</PolicyState>
  </PolicyDetails>
</PolicyInformation>
</Detail>
</CoverageResponseDocument>
</SOAP-ENV:Body>
</SOAP-ENV:Envelope>
```

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1778. Appendix B: Unconfirmed Reason Codes

A. Original Unconfirmed Reason Codes from ASC X12 Schema

1	Incorrect Data Format
2	Missing Unique Key
3	Missing NAIC Code
4	Missing VIN
5	Missing Verification Date
6	Unauthorized Requestor
7	System Cannot Locate Unique Key Information
8	System Found Unique Key - No Coverage on Date
9	System Found Unique Key - VIN Cannot Be Verified
10	System Found VIN - Unique Key Cannot Be Verified
11	System Cannot Locate Policy Information - Manual Search In Progress
12	System Unavailable

B. Newer Unconfirmed Reason Codes from ASC X12 Schema 00200706 and Later

IDF	Incorrect Data Format
SYSU	System Unavailable
UREQ	Unauthorized Requestor
NAIC1	NAIC Code Not Submitted
NAIC2	System Cannot Locate NAIC
PKEY1	Policy Key Not Submitted
PKEY2	System Cannot Locate Policy Key Information
PKEY3	System Found Policy Key - Coverage on Verification Date Cannot Be Confirmed
PKEY4	System Found Policy Key - VIN Cannot Be Verified
POL1	System Cannot Locate Policy Information - Manual Search in Progress
VDT1	Coverage on Verification Date Cannot Be Confirmed
VDT2	Verification Date Not Submitted
VIN1	System Cannot Locate VIN
VIN2	System Found VIN - Coverage on Verification Date Cannot Be Confirmed
VIN3	System Found VIN - Policy Key Cannot Be Verified
VIN4	VIN Not Submitted

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1780. Appendix C: Vehicle Types to be Reported

Vehicle Type	Should be reported to LAIVS?
Antique	Yes
ATV	No
Boat	No
Bus	Yes
Golf Cart	Yes
Mini Truck	Yes
Mobile Home/House Trailer	No
Motorcycle	Yes
Motor Home	Yes
Passenger	Yes
Semi-Trailer	No
Trailer	No
Truck	Yes
Truck Tractor	Yes
Trike	Yes
Van	Yes

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1782. Appendix D: Error Codes in Row Error Files

Error Code	Field Id	Field Name
E01	1	POLICY TYPE
E02	2	NAIC
E03	3	POLICY NUMBER
E04	4	EFFECTIVE DATE
E05	5	VIN
E06	6	LAST NAME or ORGANIZATION
E07	7	PREFIX NAME ABBR
E08	8	MIDDLE NAME
E09	9	FIRST NAME
E10	10	SUFFIX NAME
E11	11	FEIN
E12	12	ADDRESS
E13	13	CITY
E14	14	STATE
E15	15	ZIP
E16	16	COMMERCIAL INDICATOR
E18	18	POLICY EXPIRATION DATE

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1784. Appendix E: Definitions

Book of Business (BOB)—a file that must be submitted to LAIVS at least once a calendar month that includes specified policy, vehicle, and customer information for all active policies with minimum liability coverage. Insurance providers who are not hosting a web service or whose web services do not support VIN broadcasting must provide BOB data on a weekly basis.

Decryption Error File—this file will be generated if a PGP decryption error occurs. Decryption errors can happen for the following reasons: the file sent by insurance provider was not encrypted, the file sent by insurance provider was improperly encrypted, or the file sent by insurance provider was encrypted using the wrong PGP key.

DPS—Louisiana Department of Public Safety.

Fleet Policy—a policy insuring a business with a fleet of five or more vehicles registered in Louisiana for which VIN information is not maintained on each vehicle. However, if the insurance provider does maintain the VIN of each vehicle within the fleet, the filing must be reported on a vehicle-by-vehicle basis.

FTP (File Transfer Protocol)—standard network protocol used to transfer computer files from one host to another host over a TCP-based network.

IICMVA—Insurance Industry Committee on Motor Vehicle Administration.

LSP—Louisiana State Police.

NAIC Number—the number issued by the National Association of Insurance Commissioners to licensed and affiliated insurance providers across the U.S.

OK File—If there are no errors in the BOB file submitted by the insurance provider, an OK file will be generated.

OMV—Louisiana Office of Motor Vehicles.

Reject File—this file will be generated if LAIVS cannot read the file or if the file is improperly formatted and the whole file is being rejected. The file may be rejected for the following reasons: the file is not formatted properly, the

trailer has a non-zero record count but detail records of the file are missing, the length of each record (line) is not up to the length specified in the guide, the end of a record missing carriage return and line feed (Hexadecimal '0D 0A').

Row Error File—row error files are generated when the overall file format sent by the insurance provider is okay but some of the rows have errors including mandatory fields missing and invalid field formats. The row error file will contain only the records that are in error. The remaining records sent with the original file will be processed by LAIVS and will not appear in the file. Each error record will have the original row sent by the insurance provider followed by a 3 digit Error Code. The format of the Error Code will be E followed by the Field ID of the invalid/missing field. For example, the Error Code for a row with an invalid NAIC number will be "E02".

VIN Broadcasting—if the VIN in the verification request message matches an insured vehicle but the policy number in the request does not match the insurance policy number, then the insurance provider's web service should be able to indicate that the vehicle is covered. This is known as "VIN broadcasting" or "unknown carrier request".

VIN No-Match File—the VIN No-Match files are generated if any of the VINs submitted by the insurance provider do not match VINs of vehicles registered in LA. The VIN No-Match file will include all the records where the VIN did not match. Each record will have the original row sent by the insurance provider followed by "E05", the 3 digit error code indicating VIN mismatch.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1786. Model User Guide for Implementing Online Insurance Verification

A. The Department of Public Safety and Corrections, Office of Motor Vehicles, hereby adopts by reference, the *Model User Guide for Implementing Online Insurance Verification - Using Web Services to verify evidence of auto liability insurance*, version 5.0 April 18, 2012, by the Insurance Industry Committee on Motor Vehicle Administration, effective date: August 20 2015, hereinafter referred to as the model user guide.

B. A copy of the model user guide shall be on file at the Office of State Register, Divisions of Administration, Third Street, Baton Rouge, LA 70802, and copies are available at the Office of Motor Vehicles Headquarters, 7979 Independence Blvd., Ste. 301, Baton Rouge, LA 70806 or P.O. Box 64886, Baton Rouge, LA 70896. A copy is also available at the following link: http://ola.dps.louisiana.gov/News_PDFs/Financial%20Responsibility%20Model%20UserGuide%20V1.pdf

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 41:

§1788. Invalid Vehicle Type-Use

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2856 (December 2004), repealed LR 41:

§1789. Declaratory Orders and Rulings

Repromulgated as § 1757.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 24:1780 (September 1998), repromulgated LR 30:2856 (December 2004), repealed LR 41:

§1790. Identification Card Specifications

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2856 (December 2004), repealed LR 41:

§1792. Proof of Liability Security

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.2.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 30:2858 (December 2004), repealed LR 41:

Family Impact Statement

The proposed Rule will not have any known or foreseeable impact on any family as defined by R.S. 49:972 D or on family formation, stability and autonomy. Specifically there should be no known or foreseeable effect on:

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

Local governmental entities have the ability to perform the enforcement of the action proposed in accordance with R.S. 40:1730.23.

Small Business Statement

The impact of the proposed Rule on small businesses has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Poverty Impact Statement

The proposed Rule amends LAC 55:III.325. These Rule changes should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973.B. In particular, there should be no known or foreseeable effect on:

1. The effect on household income, assets, and financial security;
2. The effect on early childhood development and preschool through postsecondary education development;
3. The effect on employment and workforce development;
4. The effect on taxes and tax credits;
5. The effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule do not impact or affect a "Provider." "Provider" means an organization that provides services for individuals with developmental disabilities as defined in HCR 170 of the 2014 Regular Session of the Legislature. In particular, the proposed Rule has no effect or impact on a "Provider" in regards to:

1. The staffing level requirements or qualifications required to provide the same level of service.
2. The cost to the provider to provide the same level of service.
3. The ability of the provider to provide the same level of service

Interested Persons

All interested persons are invited to submit written comments on the proposed regulation. Such comments should be submitted no later than October 15, 2015, at 4:30 p.m. to Stephen A. Quidd, P.O. Box 66614, Baton Rouge, LA 70896, (225) 925-6103, Fax:(225) 925-3974, or stephen.quidd@la.gov. A public hearing is scheduled for October 23, 2015 at 10 a.m. at 7979 Independence Blvd. Suite 301, Baton Rouge, LA 70806. Please call or e-mail in advance to confirm the time and place of meeting, as the meeting will be cancelled if the requisite number of comments is not received.

Jill P. Boudreaux
Undersecretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Specifications for Notification of Initiation, Termination, or Modification of Liability Security

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs or savings to state or local governmental units as a result of the proposed rule change. The rule change is a result of Act 641 of 2014, which created the real-time insurance database. The rule change codifies the Specifications for Notification of Initiation, Termination or Modification of Liability Security and the Louisiana Insurance Verification System (LAIVS), Implementation Guide for Insurance Providers. The rule change adopts the Model User Guide for Implementing Online Insurance Verification - Using Web Services to verify evidence of auto liability insurance - Version 5.0 April 18, 2012.

The rule change makes technical changes to Specifications for Notification of Initiation, Termination or Modification of Liability Security regarding the electronic notification requirement. This most recent version replaces the current specification in LAC 55 Part III, Chapter 17, Subchapter B, §1750 through §1792. This is an existing program utilized by the Department and there should be no costs or saving to implement these technical changes. Local governmental units do not participate in this program.

The rule change codifies the Louisiana Insurance Verification System (LAIVS), Implementation Guide for Insurance Providers that was established by the Department of Public Safety into rule. Local governmental units are not establishing this system, but it will be available to local law enforcement through internet connections and the Law Enforcement Message Switch (LEMS). The enabling legislation to create the system of real time insurance inquiries

was included in Act 641 of 2014. The system was funded through Act 15 of 2014, the general appropriations bill.

Finally, the rule change adopts The Model User Guide for Implementing Online Insurance Verification - Using Web Services to verify evidence of auto liability insurance - Version 5.0 April 18, 2012. This is the platform on which the LAIVS is based and was adopted by the Insurance Industry Committee on Motor Vehicle Administration.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will have no effect on revenue collections by state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change may result in minimal costs or economic benefit to the insurance industry as most major insurance companies are already reporting real time insurance information to other states. Small insurance companies with less than 500 vehicles are not required to participate, however, they can if they choose to do so.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no effect on competition and employment.

Jill P. Boudreaux
Undersecretary
1509#093

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Public Safety and Corrections Office of State Police

Federal Motor Carrier Safety and Hazardous Materials
(LAC 33:V.10303)

The Department of Public Safety and Corrections, Office of State Police, in accordance with R.S. 49:950 et seq., and R.S. 32:1501 et seq., gives notice of its intent to amend its rules regulating motor carrier safety and hazardous materials by updating the revision date of the adopted federal motor carrier regulations to August 10, 2015.

Title 33

ENVIRONMENTAL QUALITY

Part V. Hazardous Wastes and Hazardous Materials

Subpart 2. Department of Public Safety and Corrections—Hazardous Materials

Chapter 103. Motor Carrier Safety and Hazardous Materials

§10303. Federal Motor Carrier Safety and Hazardous Materials

A. The following federal motor carrier safety regulations and hazardous materials regulations promulgated by the United States Department of Transportation, revised as of August 10, 2015, and contained in the following parts of 49 CFR as now in effect or as hereafter amended, are made a part of this Chapter.

Hazardous Material Regulations	
Part 107	Hazardous Materials Program Procedures
Part 171	General Information, Regulations, and Definitions
Part 172	Hazardous Materials Table, Special Provisions, and Hazardous Materials Communications, Emergency Response Information, and Training Requirements

Part 173	Shippers—General Requirements for Shipments and Packagings
Part 177	Carriage by Public Highways
Part 178	Specifications for Packagings
Part 180	Continuing Qualification and Maintenance of Packagings
Motor Carrier Safety Regulations	
Part 355	Compatibility of State Laws and Regulations Affecting Interstate Motor Carrier Operations
Part 360	Fees for Motor Carrier Registration and Insurance
Part 365	Rules Governing Applications for Operating Authority
Part 367	Standards for Registration with States
Part 373	Receipts and Bills
Part 374	Passenger Carrier Regulations
Part 375	Transportation of Household Goods in Interstate Commerce: Consumer Protection Regulations
Part 376	Lease and Interchange of Vehicles
Part 379	Preservation of Records
Part 382	Controlled Substances and Alcohol Use and Testing
Part 383	Commercial Driver's License Standards; Requirements and Penalties
Part 384	State Compliance with Commercial Driver's License Program
Part 385	Safety Fitness Procedures
Part 386	Rules of Practice for Motor Carrier, Broker, Freight Forwarder and Hazardous Materials Proceedings
Part 387	Minimum Levels of Financial Responsibility for Motor Carriers
Part 388	Cooperative Agreements with States
Part 389	Rulemaking Procedures-Federal Motor Carrier Safety
Part 390	Federal Motor Carrier Safety Regulations; General
Part 391	Qualifications of Drivers
Part 392	Driving of Commercial Motor Vehicles
Part 393	Parts and Accessories Necessary for Safe Operation
Part 395	Hours of Service of Drivers
Part 396	Inspection, Repair, and Maintenance
Part 397	Transportation of Hazardous Materials; Driving and Parking Rules

AUTHORITY NOTE: Promulgated in accordance with R.S. 32: 1501 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 14:31 (January 1988), amended LR 17:1115 (November 1991), LR 19:351 (March 1993), LR 20:58 (January 1994), LR 24:956 (May 1998), LR 24:2321 (December 1998), LR 29:711 (May 2003), LR 30:447 (March 2004), LR 32:641 (April 2006), LR 34:882 (May 2008), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, LR 37:1613 (June 2011), LR 38:1417 (June 2012), amended by the Department of Public Safety and Corrections, Office of State Police, LR 40:371 (February 2014), LR 41:

Family Impact Statement

1. The effect of this Rule on the stability of the family. This Rule should not have any effect on the stability of the family.

2. The effect of this Rule on the authority and rights of parents regarding the education and supervision of their children. This Rule should not have any effect on the authority and rights of parents regarding the education and supervision of their children.

3. The effect of this Rule on the functioning of the family. This Rule should not have any effect on the functioning of the family.

4. The effect of this Rule on family earnings and family budget. This Rule should not have any effect on family earnings and family budget.

5. The effect of this Rule on the behavior and personal responsibility of children. This Rule should not have any

effect on the behavior and personal responsibility of children.

6. The effect of these rules on the ability of the family or local government to perform the function as contained in the proposed Rule. This Rule should not have any effect on the ability of the family or local government to perform the function as contained in the proposed rules.

Poverty Impact Statement

The impact of the proposed Rule on child, individual, or family poverty has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on poverty in relation to individual or community asset development as provided in the R.S. 49:973.

The agency has considered economic welfare factors and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on poverty.

Small Business Statement

The impact of the proposed Rule on small businesses has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act.

The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to: Paul Schexnayder, Post Office Box 66614, Baton Rouge, LA 70896. Written comments will be accepted through October 15, 2015.

Jill P. Boudreaux
Undersecretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Federal Motor Carrier Safety and Hazardous Materials

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule changes will have no anticipated impact on state or local government expenditures.

The proposed rule updates the revision date of adopted federal motor carrier regulations.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There should be no effect on revenue collections of state or local governmental units as a result of this rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There should be no costs or economic benefits to any person or group, as a result of this rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no effect on competition and employment.

Jill P. Boudreaux
Undersecretary
1509#043

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Revenue
Office of Alcohol and Tobacco Control**

Caterer’s Permits (LAC 55:VII.325)

Under the authority of R.S. 26:793 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, proposes to amend LAC 55:VII.325 relative to caterer’s permits.

The proposed amendment to the above-Referenced Rule is offered under the authority delegated by R.S. 26:793 to provide for a class A-caterer’s permit for persons who hold a written concessions agreement to provide food and beverage concession services at any arena, stadium, race track, amphitheater, auditorium, theater, civic center, convention center, or similar facility that is primarily designed and used for live artistic, theatrical, cultural, educational, charitable, musical, sporting, nationally sanctioned automobile or horse racing or entertainment events.

**Title 55
PUBLIC SAFETY**

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 3. Liquor Credit Regulations

§325. Caterer’s Permits

A. The Office of Alcohol and Tobacco Control may issue a class A-caterer's permit to persons who meet the qualifications and criteria of either Paragraph 1, 2, 3 or 4 below.

1. - 3.c. ...

4. Persons who do not otherwise qualify for a retail dealer permit pursuant to the provisions of R.S. 26:71.1 or R.S. 26:271.2, but who hold a written concessions agreement to provide food and beverage concession services at any arena, stadium, race track, amphitheater, auditorium, theater, civic center, convention center, or similar facility that is primarily designed and used for live artistic, theatrical, cultural, educational, charitable, musical, sporting, nationally sanctioned automobile or horse racing or entertainment events will be allowed to obtain a class A-caterer’s permit for the premises under all of the following conditions.

a. The permit holder must have a written concession agreement to provide food and beverages concession services from the owner, operator or lessee of the premises. The written concession agreement shall contain an affirmative provision disavowing the right of any party to engage in conduct prohibited by the alcoholic beverage control laws and regulations.

b. The permit holder must not be owned, in whole or in part, by the owner, operator, lessee, subsidiary, agent, or company managing the premises.

c. The permit holder must not own, in whole or part, or manage the premises.

d. The permit holder shall receive no monetary benefit, directly or indirectly, by any scheme or device or in any form or degree from the alcoholic beverage industry including a benefit in the form of capital improvements, furniture, fixtures, equipment or supplies except as provided in Subsection C of this Section, unless otherwise allowed in the alcoholic beverage control laws and regulations. The provision and use of indoor or outdoor signs, or other advertising or marketing products, including mobile dispensing equipment, logo or other branding of an alcoholic beverage manufacturer or wholesaler pursuant to an advertising or sponsorship agreement with the owner, operator, promoter, lessee party with a right of use or management company of the premises, and the use of proceeds of a manufacturer’s or wholesaler’s purchase of indoor or outdoor signs or other advertising and marketing products or rights from the owner, operator, promoter, lessee, party with a right of use or management company of the premises, shall not be construed to be a direct or indirect monetary benefit to the permit holder.

e. The permit holder shall not receive any direct monetary benefit from advertising, promotional or sponsorship revenues generated by operation of the premises.

f. The owner, operator, lessee, subsidiary, agent or company managing the premises nor any alcoholic beverage manufacturer or wholesaler or agent thereof shall not, directly or indirectly, control the quantity or brand of alcoholic beverages bought, sold or served by the holder of the class A-caterer permit.

g. This class A-caterer’s permit shall not be utilized to sell, serve or otherwise engage in business as an alcoholic beverage dealer at any premises where the primary purpose is the sale of food or alcoholic beverages, including, but not limited to, a bar, nightclub, restaurant, hotel, bowling alley, pool hall, or dance hall, or any premises that derives 75 percent or more of its gross revenue from the on-premise sale of alcoholic beverages.

B.1. - B.3. ...

4. A class A-caterer issued under Paragraphs 1, 2 and 3 of Subsection A of this Section must provide the Office of Alcohol and Tobacco Control with written notice of the date, time, and place of each catered event at least one week prior to the date of the event.

B.5. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:793.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Alcoholic Beverage

Control, LR 19:904 (July 1993), amended by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 26:2631 (November 2000), LR 34:1633 (August 2008), LR 41:

Family Impact Statement

The proposed rulemaking has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed rulemaking will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

Provider Impact Statement

The proposed rulemaking has no known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session.

Public Comments

Interested persons may submit written comments until 4 p.m. on October 30, 2015 to Commissioner Troy M. Hebert, Office of Alcohol and Tobacco Control, P.O. Box 66404, Baton Rouge, LA 70896 or at troy.hebert@atc.la.gov.

Public Hearing

A public hearing will be held on Friday, October 30, 2015 at 4 p.m. in the Office of Alcohol and Tobacco Control at 5855 Archives Avenue, Ste. 305 in Baton Rouge, LA.

Troy Hebert
Commissioner

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Caterer’s Permits**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed amendment to the above-referenced rule provides for a Class A – Caterer’s permit for persons who hold a written concessions agreement to provide food and beverage concession services at any arena, stadium, race track, amphitheater, auditorium, theater, civic center, convention center, or similar facility that is primarily designed and used for live artistic, theatrical, cultural, educational, charitable, musical, sporting, nationally sanctioned automobile or horse racing or entertainment events.

The establishment of a new permit is not expected to materially impact resources needed to administer the effort. Promulgation of this proposed rule and/or amendment will not result in any costs to state or local governmental units. Nor is it likely to result in any savings to any such units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The impacted parties are currently obtaining permits that adoption of the proposed rule will allow to more closely match stated missions. Fees for this permit will remain the same as the current permits. Thus, the new permit will better serve for informative purposes but fees, etc., will remain as they are in current practice. Promulgation of this proposed rule and/or amendment will not affect revenue collections of state or local governmental units whatsoever.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Promulgation of this proposed rule and/or amendment will not result in any costs and/or economic benefits to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule and/or amendment will not effect competition and employment.

Troy Hebert
Commissioner
1509#014

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Revenue
Office of Alcohol and Tobacco Control**

**Regulation IX—Prohibition of Certain
Unfair Business Practices (LAC 55:VII.317)**

Under the authority of R.S. 26:150 and in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, proposes to amend LAC 55:VII.317 relative to unfair business practices.

This proposed amendment to the above-referenced rule is offered under authority of R.S. 26:150 to promulgate rules relative to unfair business practices to provide for regulations for the use of advertisements (including social media advertisements), sponsorships, retailer trade associations, third-party promotional companies, reasonable retail entertainment and events at unlicensed venues.

Title 55

PUBLIC SAFETY

Part VII. Alcohol and Tobacco Control

Subpart 1. Beer and Liquor

Chapter 3. Liquor Credit Regulations

**§317. Regulation IX—Prohibition of Certain Unfair
Business Practices**

A. Definitions

Advertisement—includes any written or verbal statement, illustrations, or depiction which is in, or calculated to induce sales in, interstate or foreign commerce, or is disseminated by mail, whether it appears in a newspaper, magazine, trade booklet, menu, wine card, leaflet, circular, mailer, book insert, catalog, promotional material, sales pamphlet, or in any written, printed, graphic, or other matter accompanying the bottle, representations made on cases or in any billboard, sign, other outdoor display, public transit card, other periodical literature, publication, or in a radio or television broadcast, or in any other media; except that such term shall not include:

a. any label affixed to any bottle of distilled spirits or container or wine or malt beverages; or any individual covering carton, or other container of the bottle or container which constitute a part of the labeling under federal law and regulations; or

b. any editorial or other reading material (*i.e.* news release) in any periodical or publication or newspaper for the publication of which no money or valuable consideration is paid or promised, directly or indirectly, by any permittee, and which is not written by or at the direction of the permittee.

* * *

Retailer Trade Association—an association or similar designation with a majority of its members holding a state

retail alcoholic beverage permit that is registered and in good standing with the Louisiana Secretary of State as a non-profit entity who has applied with and received approval from the Internal Revenue Service as a 501(c)(6) tax exempt organization in good standing.

Social Media Advertisement—any advertisement disseminated by social network services, video sharing sites, blogs, microblogs, links and quick response codes.

* * *

B. - C.2.b.iii. ...

c. Outside Signs. The furnishing of outside signs by an industry member to licensed retail dealers is prohibited. It is unlawful for an industry member to, directly or indirectly, give, rent, loan, sell or in any other manner provide a retail dealer with any form of outside signage except as expressly allowed by the alcoholic beverage control laws and regulations.

i. This prohibition shall not be construed to apply to any advertising, branding or labeling artwork that is smaller than, proportionate in size and affixed to any equipment supplied to the holder of a type A, B, or C special event permit holder in accordance with Subsection F of Section 323 of this Chapter.

d. - e.vi. ...

vii. In conjunction with events held on regular licensed retail premises, all restrictions on advertising and signage will remain in full force and effect, except that temporary paper signs and posters may be used inside the premises to advertise the event for not more than 31 days prior to the event. A wholesaler or manufacturer may list the name and address of one or more retail dealers and the date and time of one or more events in a social media advertisement for not more than 31 days prior to the event provided that:

(a). the social media advertisement does not also contain the retail price for any product;

(b). the retail dealer shall not provide the industry member with anything of value as a condition to having its business listed in the social media advertisement; and

(c). the wholesaler or manufacturer does not directly or indirectly, incur any cost or expend anything of value in connection with the social media advertisement.

f. - h.v. ...

vi. A wholesaler or manufacturer may promote a sampling event by listing the name and address of one or more retail dealers and the date and time of one or more sampling events in a social media advertisement for not more than 31 days prior to the sampling provided that:

(a). the social media advertisement does not also contain the retail price for any product;

(b). the retail dealer shall not provide the industry member with anything of value as a condition to having its business listed in the social media advertisement; and

(c). the wholesaler or manufacturer does not directly or indirectly, incur any cost or expend anything of value in connection with the social media advertisement.

vii. Industry members may use a third-party promotional company to conduct product samplings under the following conditions:

(a). the industry member has a written contractual agreement with the third-party promotional company that clearly defines the scope of the activities to be conducted by the promotional company on behalf of the industry member and the contractual agreement is provided to the office of alcohol and tobacco control prior to any representation by the third-party promotional company on behalf of the licensed industry member;

(b). the third-party promotional company shall comply with all provisions of the alcoholic beverage control laws and regulations including, but not limited to, the provisions of this Section;

(c). violations of the alcoholic beverage control laws or regulations by a third-party promotional company or any of its representatives shall be considered the industry member's act for purposes of penalties or suspension or revocation of the industry member's alcoholic beverage permit;

(d). the third-party promotional company shall not be directly or indirectly owned, created, operated, inappropriately influenced, or controlled by an alcoholic beverage retail dealer licensed by the state of Louisiana or any person holding an interest therein;

(e). the industry member or third-party promotional company shall not give the retail dealer anything of value, unless otherwise allowed in the alcoholic beverage control laws and regulations;

(f). the name and permit number of the industry member and the name of the third-party promotional company shall be provided on all documents required to be submitted to the office of alcohol and tobacco control by this Section;

(g). the industry member shall ensure that all agents of the third-party promotional company possess valid Louisiana responsible vendor certifications prior to conducting any samplings of alcoholic beverages on the industry member's behalf;

(h). the third-party promotional company shall not offer for sale or solicit any orders for the sale of any alcoholic beverages produced or supplied by the industry member; and

(i). any sampling conducted by a third-party promotional company on behalf of an industry member shall count as a sampling conducted by the industry member.

i. - n.viii. ...

o. Retail Trade Associations. Industry members may participate in the activities of a retailer-affiliated trade association, as defined in this Section, only in the following ways:

i. by advertising in convention publications and/or programs, if the advertising fees are the same rate offered to all other participants at the event;

ii. by being an associate member;

iii. by renting display booth space if the rental fee is the same as paid by all exhibitors at the event;

iv. by purchasing tickets to functions and paying registration fees if the payments or fees are the same as paid by all attendees, participants or exhibitors at the event;

v. by exhibiting their products and offering single serve portions of their products at no cost for immediate consumption on the premises of the exhibition without having to obtain a special event permit;

vi. all state and parish or municipal excise taxes due shall be paid prior to the provision of any products for consumption at exhibition events;

vii. the industry member shall provide the Office of Alcohol and Tobacco Control with written notice of the location, date(s) and time(s) it intends to exhibit any product no less than five business days prior to the exhibition; and

viii. the industry member's participation with a retailer trade association shall not benefit one or more of the trade association's members to the exclusion, in whole or in part, of the other retail members.

p. Reasonable Retail Entertainment. The furnishing of food and beverages, entertainment and recreation by an industry member to a retail dealer or its owners, officers, members, directors, stockholders, employees, agents, managers, or subsidiaries is prohibited except under all of the following conditions:

i. the value of food, beverages, entertainment and recreation shall not exceed \$500.00 per person on only one occasion per week;

ii. the providing industry member must accompany the receiving retail member to the event at which the food, beverages, entertainment and/or recreation are provided;

iii. in the course of providing food, beverages, entertainment or recreation under this rule, upper tier industry members may only furnish local transportation;

iv. food, beverages, recreation and entertainment may also be provided during attendance at a convention, conference, or similar event so long as the primary purpose for the attendance of the retailer at such event is not to receive benefits under this regulation; and

v. each industry member shall keep complete and accurate business records and/or other documents reflecting all expenses incurred for retailer entertainment for two years.

q. Events at Unlicensed Venues. The provisions of R.S. 26:287 and this Section shall not be construed to prohibit an alcoholic beverage manufacturer, wholesale dealer or retail dealer from sponsoring, providing sponsorship signs, promoting or advertising an alcoholic beverage brand or product, or purchasing, displaying, and/or transmitting indoor or outdoor signs or other advertising and marketing products at a premises that does not hold a retail alcoholic beverage permit, or for any event at such premises, by agreement with the owner, operator, promoter, lessee, a party with a right of use, or management company of the unlicensed venue if all alcoholic beverages are sold and/or served at the premises by a person holding a class A-caterer's permit issued in accordance with these regulations and all of the following conditions apply:

i. the caterer is engaged to provide food and beverage concession services pursuant to a written agreement with the owner, operator, promoter, lessee or management company of the premises where alcoholic beverages are sold and/or served;

ii. the caterer receives no monetary benefit, directly or indirectly by any scheme or device or in any form or degree from the manufacturer, wholesaler, or retailer in connection with the provision or purchase of sponsorship, signs, advertising or marketing products from the owner,

operator, promoter, lessee, party with a right of use, or management company of the premises. The provision of indoor or outdoor signs or other advertising or marketing products, including mobile dispensing equipment which display the name, logo, or other branding of an alcoholic beverage manufacturer, or wholesaler pursuant to an advertising or sponsorship agreement with the owner, operator promoter, lessee, a party with a right of use or management company of the premises, and the use of proceeds of a manufacturer's, or wholesaler's, purchase of indoor or outdoor signs or other advertising and marketing products from the owner, operator, promoter, lessee, a party with a right of use or management company of the premises conducting events to enhance or otherwise benefit an event or the venue conducting events shall not be construed to be a direct or indirect monetary benefit to the caterer or any retail dealer located on or around the premises of the event or venue;

iii. the caterer is not owned, in whole or in part, by the owner, operator, promoter, lessee or management company of the premises, or a subsidiary, agent or manager of the event or premises that is a direct recipient of such monetary benefit as defined in this Subparagraph;

iv. the owner, operator, promoter, lessee or management company of the premises shall not directly or indirectly control or otherwise influence the quantity or brand of alcoholic beverages bought or sold by the caterer unless the caterer is owned, in whole or in part, by the owner of the premises who is not the direct recipient of such monetary benefit as defined in this Subparagraph; and

v. no part of the cost of an advertisement, sponsorship or promotion authorized by this subparagraph may be charged to or paid by a wholesale dealer unless the wholesaler either contracts directly with the owner, operator, promoter, lessee or management company of the unlicensed premises for the advertisement, sponsorship, or promotion or the wholesaler is a party to the advertising, sponsorship or promotion agreement between the manufacturer and the owner, operator, promoter, lessee or management company of the unlicensed premises.

D. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 26:150.

HISTORICAL NOTE: Promulgated by the Department of Public Safety, Office of Alcoholic Beverage Control, LR 4:463 (November 1978), amended LR 5:11 (January 1979), amended by the Department of Public Safety and Corrections, Office of Alcoholic Beverage Control, LR 17:607 (June 1991), LR 20:671 (June 1994), amended by the Department of Revenue and Taxation, Office of Alcoholic Beverage Control, LR 22:116 (February 1996), LR 26:2631 (November 2000), LR 28:1484 (June 2002), LR 31:1344 (June 2005), amended by the Department of Revenue, Office of Alcohol and Tobacco Control, LR 35:89 (January, 2009), LR 38:1286 (May 2012), LR 38:2938 (November 2012), LR 41:

Family Impact Statement

The proposed rulemaking has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed rulemaking will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

Provider Impact Statement

The proposed rulemaking has no known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session.

Public Comments

Interested persons may submit written comments until 4 p.m. on October 30, 2015 to Commissioner Troy M. Hebert, Office of Alcohol and Tobacco Control, P.O. Box 66404, Baton Rouge, LA 70896 or by email to troy.hebert@atc.la.gov.

Public Hearing

A public hearing will be held on Friday, October 30, 2015 at 4 p.m. in the Office of Alcohol and Tobacco Control at 8585 Archives Avenue, Ste. 305 Floor in Baton Rouge, LA.

Troy Hebert
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Regulation IX—Prohibition of Certain Unfair Business Practices

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This proposed amendment to the above-referenced rule provides for regulations for the use of social media advertisements, retailer trade associations, third party promotional companies, reasonable retail entertainment, sponsorship, outside signage, samplings and events at unlicensed venues. It also defines Advertisement, Retailer Trade Association and a Social Media Advertisement.

The proposed rule does not materially impact enforcement or accounting duties to the extent that departmental resources will be impacted. Thus, promulgation of this proposed rule and/or amendment will not result in any costs to state or local governmental units. Nor is it likely to result in any savings to any such units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There are no additional fees or new permitting practices included in the proposed rule. Promulgation of this proposed rule and/or amendment will not affect revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Promulgation of this proposed rule and/or amendment will not result in any costs and/or economic benefits to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule and/or amendment will not effect competition and employment.

Troy Hebert
Commissioner
1509#013

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Department of State Business Services Division

Foreign Corporations Penalty Schedule
(LAC 19:V.701 and 703)

Pursuant to the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and under the authority of R.S. 12:314.1 and R.S. 36:742, the secretary of state proposes to adopt a penalty schedule for foreign corporations transacting business in this state without a valid certificate of authority from the Department of State.

Title 19

CORPORATION AND BUSINESS

Part V. Secretary of State

Subpart 3. Foreign Corporations

Chapter 7. Foreign Corporations Not Registered with the Department of State

§701. Notification of Foreign Corporation Not Registered with the Department of State

A. When the Department of State is made aware that a foreign corporation is transacting business in this state without a valid certificate of authority, the secretary of state shall notify the foreign corporation by certified mail (return receipt requested) that a certificate of authority is required and must be obtained within 30 days of receipt of the notification.

B. If the foreign corporation does not comply and obtain the certificate of authority within the 30-day period after notification, the Department of State shall investigate the foreign corporation and determine the penalty to be assessed in accordance with the penalty schedule detailed in §703. The foreign corporation shall be notified by certified mail (return receipt requested) that the penalty has been assessed and will have 60 days in which to pay the penalty to the Department of State.

C. If the foreign corporation does not pay the penalty as assessed within the 60-day period, the secretary of state shall notify the attorney general to institute proceedings against the foreign corporation to collect such penalty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 12:314.1 and R.S. 36:742.

HISTORICAL NOTE: Promulgated by the Department of State, Business Services Division, LR 41:

§703. Foreign Corporation Penalty Schedule

A. The secretary of state hereby adopts the following penalty schedule for foreign corporations transacting business in this state without a valid certificate of authority.

1. For a foreign corporation transacting business in the state for less than one year, the penalty fee shall be \$500.

2. For a foreign corporation transacting business in the state for greater than one year but less than three years, the penalty fee shall be \$750.

3. For a foreign corporation transacting business in the state for greater than three years, the penalty fee shall be \$1,000.

B. The acceptable forms of payment are: check, money orders, cashier's check, and credit card. For any check

returned to the department as NSF, there will be a charge of \$25. There will be a \$5 service charge for payments by credit card. Payment shall either be hand delivered to the department (Business Services Division, Twelve United Plaza, 8585 Archives Avenue, Baton Rouge, LA) or mailed to the department (Department of State, Business Services Division, P.O. Box 94125, Baton Rouge, LA 70804-9095).

AUTHORITY NOTE: Promulgated in accordance with R.S. 12:314.1 and R.S. 36:742.

HISTORICAL NOTE: Promulgated by the Department of State, Business Services Division, LR 41:

Family Impact Statement

The proposed Rule cited in LAC 19:V.Chapter 7 regarding foreign corporations should not have any known or foreseeable impact on any family as defined by R.S. 49:927 or on family formation, stability and autonomy. Specifically, there should be no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children; and
6. the ability of the family or a local government to perform the function as contained in the proposed amendments to the Rule.

Poverty Impact Statement

The proposed Rule cited in LAC 19:V.Chapter 7 regarding foreign corporations should not have any known or foreseeable impact on poverty as defined by R.S. 49:973. Specifically, there should be no known or foreseeable effect on:

1. the household income, assets and financial security;
2. early childhood development and preschool through postsecondary education development;
3. employment and workforce development;
4. taxes and tax credits; and
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

The proposed Rule on small business has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small business as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small business.

Provider Impact Statement

The proposed Rule does not have any known or unforeseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Steve Hawkland, Deputy General Counsel, Legal Division, Department of State, P.O. Box 94125, Baton Rouge, LA 70804-9125. He will be responsible for responding to inquiries regarding the proposed amendments to various sections of the Rule. The deadline for the Department of State to receive written comments is 4:30 p.m. on Wednesday, October 28, 2015 after the public hearing.

Public Hearing

A public hearing on the proposed Rule is scheduled for Tuesday, October 27, 2015 at 1 p.m. in the auditorium at the State Archives Building, 3851 Essen Lane, Baton Rouge, LA. At that time, all interested persons will be afforded the opportunity to submit data, views, or arguments either orally or in writing.

Tom Schedler
Secretary of State

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Foreign Corporations Penalty Schedule

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs or savings to state or local governmental units as a result of the proposed rule. The proposed rule establishes procedures related to investigating and sets fine schedules penalizing foreign (out-of-state and international) corporations who conduct business in Louisiana without a valid certificate of authority from the Secretary of State. Noncompliant corporations must register with the Secretary of State within 30 days of being notified of noncompliance. All foreign corporations operating in Louisiana are currently in compliance. Existing Secretary of State personnel would conduct an investigation at no additional cost if it were necessary.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule may have a nominal effect on revenue collections for the Secretary of State. The proposed rule allows for the Secretary of State to penalize foreign corporations up to \$1,000 for conducting business in Louisiana without a certificate of authority. The Secretary of State anticipates no effect on revenues as a result of issuing penalties under the proposed rule because all noncompliant foreign corporations have applied for a certificate of authority within the 30 day time frame after being notified of noncompliance.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule may impact foreign corporations by instituting a fine of up to \$1,000 for conducting business in Louisiana without a certification of authority from the Secretary of State.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule adoption will have no effect on competition and employment.

Joe R. Salter
Undersecretary
1509#039

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Transportation and Development Professional Engineering and Land Surveying Board

Waiver of the Fundamentals of Engineering Examination and Personal References (LAC 46:LXI.1303 and 1701)

Under the authority of the Louisiana professional engineering and land surveying licensure law, R.S. 37:681 et seq., and in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Louisiana Professional Engineering and Land Surveying Board has initiated procedures to amend its rules contained in LAC 46:LXI.1303 and 1701.

This is a technical revision of existing rules under which LAPELS operates. The revisions include the repeal of the Rule regarding waivers of the fundamentals of engineering examination and a clarification of who is prohibited from serving as a personal reference for an applicant for licensure.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXI. Professional Engineers and Land Surveyors

Chapter 13. Examinations

§1303. Waiver of the Fundamentals of Engineering Examination

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:688.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Board of Registration for Professional Engineers and Land Surveyors, LR 4:88 (March 1978), amended LR 5:113 (May 1979), LR 6:735 (December 1980), LR 7:647 (December 1981), LR 10:805 (October 1984), LR 14:449 (July 1988), LR 17:804 (August 1991), amended by the Department of Transportation and Development, Professional Engineering and Land Surveying Board, LR 27:1030 (July 2001), LR 30:1714 (August 2004), LR 32:1620 (September 2006), LR 39:2282 (August 2013), repealed LR 41:

Chapter 17. Applications and Fees

§1701. Applications

A. ...

B. Applications for licensure as a professional engineer or professional land surveyor shall be completed on the most current forms developed by the board. The application shall contain statements showing the applicant's qualifications, and the names and addresses of five personal references. None of the five personal references can be an immediate family member or business associate of the applicant. For purposes of this §1701.B, immediate family member is defined as a spouse, child, spouse of a child, sibling, spouse of a sibling, sibling of a spouse, parent, parent of a spouse, stepparent or stepchild. For purposes of this §1701.B, business associate is defined as a subordinate of the applicant, or a consultant or contractor who provides goods or services to the applicant or to a business, entity or agency in which the applicant is an owner, member, officer, director, trustee, partner, principal, manager, employee, associate, consultant or contractor. Three or more of the five personal references furnished by an applicant for licensure as a professional engineer shall be professional engineers holding valid licenses to engage in the practice of engineering issued to them by proper authority of a state, territory, or possession

of the United States, or the District of Columbia. Three or more of the five personal references furnished by an applicant for licensure as a professional land surveyor shall be professional land surveyors holding valid licenses to engage in the practice of land surveying issued to them by proper authority of a state, territory, or possession of the United States, or the District of Columbia. Engineering experience shall be verified by a person having direct knowledge of the quality of the applicant's engineering work, preferably a professional engineer holding a valid license to engage in the practice of engineering issued to him/her by proper authority of a state, territory, or possession of the United States, or the District of Columbia. Land surveying experience shall be verified by a person having direct knowledge of the quality of the applicant's land surveying work, preferably a professional land surveyor holding a valid license to engage in the practice of land surveying issued to him/her by proper authority of a state, territory, or possession of the United States, or the District of Columbia.

C. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:688.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Board of Registration for Professional Engineers and Land Surveyors, LR 5:112 (May 1979), amended LR 5:365 (November 1979), LR 7:646 (December 1981), LR 11:362 (April 1985), LR 19:57 (January 1993), amended by the Department of Transportation and Development, Professional Engineering and Land Surveying Board, LR 27:1032 (July 2001), LR 30:1717 (August 2004), LR 37:2414 (August 2011), LR 38:2565 (October 2012), LR 39:2283 (August 2013), LR 41:

Family Impact Statement

In accordance with R.S. 49:953(A)(1)(a)(viii) and 972, the following Family Impact Statement is submitted with the Notice of Intent for publication in the *Louisiana Register*. The proposed Rule has no known impact on family formation, stability or autonomy.

Poverty Impact Statement

In accordance with R.S. 49:953(A)(1)(a)(ix) and 973, the following Poverty Impact Statement is submitted with the Notice of Intent for publication in the *Louisiana Register*. The proposed Rule has no known impact on child, individual or family poverty in relation to individual or community asset development.

Provider Impact Statement

In accordance with HCR No. 170 of the 2014 Regular Session, the following Provider Impact Statement is submitted with the Notice of Intent for publication in the *Louisiana Register*. The proposed Rule has no known effect on the staffing level requirements or qualifications required to provide the same level of service, the cost to the provider to provide the same level of service or the ability of the provider to provide the same level of service.

Public Comments

Interested parties are invited to submit written comments on the proposed Rule through October 12, 2015 at 4:30 p.m., to Donna D. Sentell, Executive Director, Louisiana Professional Engineering and Land Surveying Board, 9643 Brookline Avenue, Suite 121, Baton Rouge, LA 70809-1433.

Donna D. Sentell
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Waiver of the Fundamentals of
Engineering Examination and Personal References**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

There are no estimated implementation costs or savings to state or local governmental units resulting from this proposed rule change. The proposed rule change (a) repeals the rule regarding waivers of the fundamentals of engineering examination requirement for certain applicants and (b) identifies those individuals who are prohibited from serving as personal references for applicants for licensure.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE
OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on revenue collections of state or local governmental units as a result of this proposed rule change.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL
GROUPS (Summary)**

Those few applicants who are no longer able to obtain a waiver of the fundamentals of engineering examination requirement will now pay an examination fee to a third-party, private entity. Examination fees are set by private examiners.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

The proposed rule change will have no effect on competition or employment.

Donna D. Sentell
Executive Director
1509#030

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Northwest Louisiana Game and Fish Preserve
(LAC 76:III.339 and 341)

Pursuant to the authority of Louisiana Revised Statutes, Title 56, Sections 6 and 727, the Louisiana Wildlife and Fisheries Commission hereby advertises its intent approve and promulgate regulations on the Northwest Louisiana Game and Fish Preserve, proposed by the Northwest Louisiana Game and Fish Preserve Commission, and the Saline Lake Game and Fish Preserve, proposed by the Saline Game and Fish Preserve Commission.

Title 76

WILDLIFE AND FISHERIES

Part III. Game and Fish Preserves and Sanctuaries

**Chapter 3. Particular Game and Fish Preserves,
Wildlife Management Areas, Refuges and
Conservation Areas**

§339. Northwest Louisiana Game and Fish Preserve

A. Waterfowl Hunting Regulations for Northwest Louisiana Game and Fish Preserve

1. Hunting within 350 yards of permitted blind locations prohibited except for the individual permitted for that location and the associated hunting party.

2. Decoys must be removed daily except that decoys may be left for the entire waterfowl season at permitted

blind locations. Decoys cannot be placed at such permitted blind locations 30 days prior to waterfowl season, and all decoys must be removed from permitted blind locations no more than 60 days from the last day of waterfowl season. Failure to comply will result in a penalty of \$25, which must be paid prior to being issued any subsequent years' blind permit.

3. Individuals must be at least 18 years old and be properly licensed to hunt waterfowl in Louisiana to apply for a blind permit.

4. Construction of or mooring of permanent blinds prohibited except that construction of or mooring of permanent blinds is allowed by permit issued by the Northwest Louisiana Game and Fish Preserve Commission in accordance with the following.

a. All blinds must be properly permitted and constructed no later than thirty days prior to the opening day of waterfowl season.

b. Permits issued must be attached to the blind in a visible location no later than thirty days prior to the opening day of waterfowl season.

c. Any blind location not properly permitted no later than 30 days prior to the opening day of waterfowl season will become an open blind location available to be permitted by the first person to request such permit.

d. A blind is not considered to be properly permitted until the permit is obtained from the Northwest Louisiana Game and Fish Preserve Commission and attached in a visible location on the blind.

e. If a blind is not permitted in the above mentioned fashion, then that blind becomes an open blind and can be permitted by anyone within the thirty day period prior to the opening day of waterfowl season.

f. No blind shall be newly constructed or moored, or be allowed to exist within 350 yards of a previously permitted and existing blind. This shall not apply to a blind which was not permitted in the previous year. Consequently, a blind may be constructed within 350 yards of a blind which was not used and properly permitted during the previous waterfowl season.

g. No individual shall be allowed to permit a blind location and fail to hunt said location during the waterfowl season. Any permitted blind location that is not used during the waterfowl season shall become an open location available for anyone to permit the following waterfowl season.

h. No individual shall be allowed to permit more than one blind within confines of the Preserve.

i. Any non-permitted constructed or moored blind will be removed from the preserve by the Northwest Louisiana Game and Fish Preserve Commission.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 41:

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6 and R.S. 56:727.

§341. Saline Lake Game and Fish Preserve

A. Waterfowl Hunting Regulations for Saline Lake Game and Fish Preserve.

1. Hunting within 350 yards of any shoreline camp or home prohibited. Hunting within 350 yards of permitted blind locations prohibited, except for the individual permitted for that location and the associated hunting party.

2. Decoys must be removed daily except that decoys may be left for the entire waterfowl season at permitted blind locations. Decoys cannot be placed at such permitted blind locations 30 days prior to waterfowl season, and all decoys must be removed from permitted blind locations no more than 60 days from the last day of waterfowl season. Failure to comply will result in a penalty of \$25, which must be paid prior to being issued any subsequent years' blind permit.

3. Construction of or mooring of permanent blinds prohibited except that construction of or mooring of permanent blinds is allowed by permit issued by the Saline Lake Game and Fish Preserve Commission in accordance with the following.

a. Individuals must be at least 18 years old and be properly licensed to hunt waterfowl in Louisiana to apply for a blind permit.

b. Blind permits will be available for purchase from August 1 through October 31 of the current year waterfowl season. Any permits not paid for in this time frame will become available on a first come, first serve basis.

c. Any false information given in conjunction with the acquisition of a blind permit will result in the permit being voided.

d. Any changes to existing permits must be submitted in writing to the Saline Lake Game and Fish Preserve Commission.

e. GPS coordinates must accompany any request for a new blind permit. These coordinates will be verified prior to approval by the commission. These coordinates must represent the exact blind location.

f. All blinds must be properly permitted and constructed no later than 30 days prior to the opening day of waterfowl season.

g. A current or previous years' permit, or photocopy of such, must be attached to the blind in a visible location no later than thirty days prior to the opening day of waterfowl season.

h. Any blind location not properly permitted no later than thirty days prior to the opening day of waterfowl season will become an open blind location available to be permitted on a first come, first serve basis.

i. A blind is not considered to be properly permitted until the permit is obtained from the Saline Lake Game and Fish Preserve Commission and attached in a visible location on the blind.

j. Blind locations will be considered abandoned and declared open by the Saline Lake Game and Fish Preserve Commission, regardless of permit status, if for one complete hunting season no usable blind structure or identification of a usable floating/boat blind is evident.

k. No blind shall be newly constructed or moored, or be allowed to exist within 350 yards of a previously permitted and existing blind. This shall not apply to a blind which was not permitted in the previous year. Consequently, a blind may be constructed within 350 yards of a blind which was not used and properly permitted during the previous waterfowl season.

l. No individual shall be allowed to permit more than one blind within confines of the Preserve.

m. Any non-permitted constructed or moored blind will be removed from the preserve by the Saline Lake Game and Fish Preserve Commission.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 41:

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:6 and R.S. 56:727.

The Secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the Commission to promulgate and effectuate this notice of intent and final Rule, including but not limited to, the filing of the fiscal and economic impact statement, the filing of the notice of intent and final Rule, and the preparation of reports and correspondence to other agencies of government.

Public Comments

Interested persons may submit written comments relative to the proposed Rule to Steve Smith, Wildlife Management Area Program Manager, P.O. Box 98000, Baton Rouge, LA 70898-9000, prior to November 5, 2015.

Family Impact Statement

In accordance with Act #1183 of 1999 Regular Session of the Louisiana Legislature, the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission hereby issues its Family Impact Statement in connection with the preceding Notice of Intent. This Notice of Intent will have no impact on the six criteria set out at R.S. 49:972(B).

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Edwin "Pat" Manuel
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Northwest Louisiana Game and Fish Preserve

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule change establishes regulations regarding the construction, placement, licensure, usage, and removal of hunting blinds and decoys on the Northwest Louisiana Game and Fish Preserve and the Saline Lake Game and Fish Preserve and is expected to have no effect on implementation costs to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is a proposed fine of \$25 for duck decoys left in the preserve more than 60 days after the season ends, which could potentially generate additional revenue. However, this proposed fee resembles the current fee in place under the internal rules and regulations these preserves currently operate under, which are not codified under the APA. The fees collected are not anticipated to exceed \$300 annually.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There is a proposed fine of \$25 for duck decoys left in the preserve more than 60 days after the season ends, which could

potentially increase costs for persons and non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change is expected to have no effect on competition or employment.

Bryan McClinton
Undersecretary
1509#055

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Removal of Abandoned Crab Traps (LAC 76:VII.367)

Notice is hereby given in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 56:322(N), that the Wildlife and Fisheries Commission proposes to amend LAC 76:VII.367 to temporarily close a portion of state inside waters to the use of crab traps in order to facilitate the removal of abandoned crab traps in these waters.

The Wildlife and Fisheries Commission has amended the provisions in LAC 76:VII.367 governing the locations of temporary crab trap closures to address problems in portions of state waters resulting from large numbers of abandoned and derelict crab traps (*Louisiana Register*, Volume 30, Number 1; Volume 31, Number 1; Volume 32, Number 2; Volume 33, Number 1; Volume 34, Number 1; Volume 36, Number 1; Volume 38, Number 1; Volume 38, Number 12; Volume 40, Number 1). The Wildlife and Fisheries Commission now proposes to amend the provisions to describe a new portion of state waters to be temporarily closed to the use of crab traps for the purpose of conducting a crab trap cleanup.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 3. Saltwater Sport and Commercial Fishery

§367. Removal of Abandoned Crab Traps

A. The use of crab traps shall be prohibited from 6:00 a.m., Friday, February 12, 2016 through 6:00 a.m. Sunday, February 21, 2016 within that portion of Jefferson Parish, Orleans Parish, St. Bernard Parish, and St. Tammany Parish as described below:

1. from a point originating from the intersection of the Lake Pontchartrain Causeway Bridge and the southern shoreline of Lake Pontchartrain; thence eastward along the southern shoreline of Lake Pontchartrain to Chef Menteur Pass; thence southward along the western shoreline of Chef Menteur Pass to Lake Borgne; thence due south a distance of one-half mile from the Lake Borgne shoreline; thence eastward and then northward a distance of one-half mile from the Lake Borgne shoreline to a point due east of Catfish Point; thence northwesterly across Rigolets Pass to the southeastern most point of land on Hog Island; thence westward along the northern shoreline of Rigolets Pass to its intersection with U.S. Highway 90; thence northward along U.S. Highway 90 to its intersection with U.S. Highway 190 (Fremaux Avenue); thence westerly along U.S. Highway 190 to Military Road; thence northward on Military road to U.S.

Highway 190 (Gause Boulevard); thence westward on U.S. Highway 190 (Gause Boulevard) to Causeway Boulevard; thence southward along Causeway Boulevard and then the Lake Pontchartrain Causeway Bridge and terminating at its intersection with the southern shoreline of Lake Pontchartrain.

B. The use of crab traps shall be prohibited from 6:00 a.m., Friday, February 19, 2016 through 6:00 a.m. Sunday, February 28, 2016 within that portion of Lafourche Parish, Jefferson Parish, Plaquemines Parish, and Cameron Parish as described below:

1. from a point originating from the intersection of the Gulf Intracoastal Waterway and the northern shoreline of Hero Canal; thence due north to a point along the northern shoreline of the Gulf Intracoastal Waterway; thence southward and then westward along the northern shoreline of the Gulf Intracoastal Waterway to a point opposite the western shoreline of Bayou Perot; thence due south to the western shoreline of Bayou Perot; thence southward along the western shoreline of Bayou Perot to Little Lake; thence southward along the western shoreline of Little Lake to 29 degrees, 30 minutes, 00 seconds north latitude; thence eastward along 29 degrees, 30 minutes, 00 seconds north latitude to the eastern shoreline of Wilkinson Canal; thence northward along the eastern shoreline of Wilkinson Canal to its termination; thence due north to the western shore of the Mississippi River; thence northwestward along the western shore of the Mississippi River to a point due east of the northern shoreline of Hero Canal; thence due west to the northern shoreline of Hero Canal; thence westward along the northern shoreline of Hero Canal and terminating at its intersection with the Gulf Intracoastal Waterway;

2. from a point originating from the intersection of the southern side of LA Highway 82 and the eastern shore of Sabine Lake, thence north along the eastern shoreline of Sabine Lake to its intersection with East Pass, thence due north to Sabine Island, thence west along the southern shoreline of Sabine Island to its westward most point, thence due west to the Texas state line, thence south along the Louisiana / Texas state line to its intersection with LA Highway 82, thence east along the southern side of LA Highway 82 and terminating at its intersection with the eastern shore of Sabine Lake.

C. All crab traps remaining in the closed area during the specified period shall be considered abandoned. These trap removal regulations do not provide authorization for access to private property; authorization to access private property can only be provided by individual landowners. Crab traps may be removed only between one-half hour before sunrise to one-half hour after sunset. Anyone is authorized to remove these abandoned crab traps within the closed area. No person removing crab traps from the designated closed areas during the closure periods shall possess these traps outside of the closed area. The Wildlife and Fisheries Commission authorizes the Secretary of the Department of Wildlife and Fisheries to designate disposal sites.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:332(N).

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission LR 30:101 (January 2004), amended LR 31:108 (January 2005), LR 32:266 (February 2006), LR 33:113 (January 2007), LR 34:97 (January 2008), LR 36:77 (January, 2010), LR 38:146 (January,

2012), LR 38:12 (December, 2012), LR 40:96 (January, 2014), LR 41:

The Secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the Commission to promulgate and effectuate this notice of intent and final rule, including but not limited to, the filing of the Fiscal and Economic Impact statement, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Family Impact Statement

In accordance with Act 1183 of 1999 Regular Session of the Louisiana Legislature, the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission hereby issues its Family Impact Statement in connection with the preceding Notice of Intent. This Notice of Intent will have no impact on the six criteria set out at R.S. 49:972(B).

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S.49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments relative to the proposed Rule to Mr. Jeff Marx, Marine Fisheries Biologist DCL-B, Marine Fisheries Section, 2415 Darnall Rd., New Iberia, LA 70560, or via email to jmarx@wlf.la.gov prior to November 1, 2015.

Edwin "Pat" Manuel
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Removal of Abandoned Crab Traps

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule change will have no impact on state or local governmental unit expenditures.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change is anticipated to have no impact on revenue collections of the state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change would prohibit the use of crab traps within portions of Jefferson, Orleans, St. Bernard, and St. Tammany parishes from 6:00 a.m., February 12, 2016 through 6:00 a.m., February 21, 2016 and within portions of Lafourche, Jefferson, Plaquemines, and Cameron parishes from 6:00 a.m., February 19, 2016 through 6:00 a.m., February 28, 2016. Crab fishermen who utilize the area proposed for closure will incur lost fishing time during the designated period and be subject to additional costs from having to temporarily remove their traps. These impacted crab fishermen must either move their traps to adjacent open fishing areas or remove their traps from the water for the duration of the closure. If the traps are not removed within the allotted time, they will be destroyed, potentially creating an additional cost to replace the traps for noncompliant fishermen.

Local seafood dealers, processors and consumers may experience a slight decrease in the availability of fresh crabs during the closure, resulting in a slightly higher price for fresh crabs in the short term. However, the crab resource will not be

lost or harmed in any way and will be available for harvest when the closed area is reopened.

Recreational saltwater anglers, commercial fishermen and individuals who operate vessels within the designated area may realize minimal positive benefits from the removal of abandoned crab traps, since encounters with abandoned traps often result in lost fishing time and damage to the vessel's lower unit and/or fishing gear. The removal of abandoned crab traps will reduce the mortality of and injuries to crabs and by-catch that become trapped and die in these traps. Thus, the removal of abandoned crab traps should provide improved fishing and reduced fishing costs.

The overall impact of the proposed area closure is anticipated to be minimal, since the duration of the closure is only for nine days during the lowest harvest time of the year, and adjacent waters will remain open for crab fishermen to continue to fish.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Since waters adjacent to the closure area will remain open for crab harvest and fishermen who fish during this time period are expected to relocate their traps, effects on competition and employment are expected to be negligible.

Bryan McClinton
Undersecretary
1509#056

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Workforce Commission Office of Workers' Compensation

Medical Treatment Guidelines
(LAC 40:I.Chapter 20-23)

The Louisiana Workforce Commission does hereby give notice of its intent to amend certain portions of the Medical Guidelines contained in the Louisiana Administrative Code, Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapters 20-21, regarding general guidelines principles for cervical spine injuries, low back pain, and chronic pain disorder. This Rule is promulgated by the authority vested in the director of the Office of Workers' Compensation found in R.S. 23:1291 and R.S. 23:1310.1(C).

Title 40

LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Subpart 2. Medical Guidelines

Chapter 20. Spine Medical Treatment Guidelines

Subchapter A. Cervical Spine Injury

§2001. Introduction

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation (OWCA) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana Workers' Compensation Act as injured workers with cervical spine injuries. Although the primary purpose of this document is advisory and educational, these guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment

in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip or overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1119 (June 2014), LR 41:

§2003. General Guideline Principles

A. - A.1. ...

2. Minimal Information for Request of Authorization. The minimum submission by a health care provider must include a current history and physical examination. As used herein, "current" means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care

team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of

achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized

treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1682 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1155 (June 2014), LR 41:

§2004. Overview of Care

A. Between 30 and 50 percent of the general population report experiencing neck pain within a given year (Carroll, 2008c). Neck pain in the workers compensation population usually occurs from whiplash associated disorders, other cervical strain injuries, or degenerative spondylolisthesis aggravated by work. Significant trauma resulting in fractures and/or spinal cord dysfunction is not covered in this overview.

B. Most individuals with documented neck pain without neurological findings are likely to recover with therapy and self-management, and not require invasive measures. Less than 10 percent of cases will experience disabling neck pain one year post injury, however, the recurrence of pain without significant impairment is common (Carroll, 2008d).

C. Whiplash can result in symptoms lasting one year in about 50 percent of cases. Specifics such as type of headrest, direction of collision, and higher speed do not seem to predict outcome (Carroll, 2008d). Severity of symptoms, including the presence of neurological findings, predicts a longer recovery period. A recent 2013 study of whiplash injuries confirmed that passive coping techniques did increase time to recovery and return to full duty (Carroll, 2013).

1. Neck Pain without Radicular Pain or Neurologic Findings

a. Multiple studies confirm the importance of the first visit and the need to follow specific processes in caring for the most common types of neck pain patients. It is important to perform a thorough neurological evaluation to clarify a specific diagnosis. Initial treatment should be similar for all patients who do not have progressive neurologic deficits; myelopathy; upper extremity weakness; suspicion for epidural abscess; tumors; or other unusual presentations. Cervical strains, suspected facet syndromes, as well as disc herniations and spinal stenosis aggravations without progressive or serious neurological findings may initially be treated conservatively but not necessarily receive

the same care as those with minor neurologic deficits. Refer to Neck Pain with Radicular and Neurological Findings.

b. All care begins with careful history taking, physical examination, and patient education. Additionally, the provider should present treatment options in order to lay the foundation for informed decision making. A detailed neurological exam should be done at the initial visit and repeated periodically to assess for any signs of progressive or continuing weakness or myelopathy. In the absence of objective motor deficits, there is normally no need to order imaging for these patients. Neither injections nor surgery are usually necessary until, after six weeks of conservative treatment has failed to result in adequate functional gains. At the first visit, patients with a benign clinical exam should understand that, with return to activity and some pain management, there is a high likelihood that their condition will improve over a period of several weeks. It is essential that neurologic exams be completed regularly to rule out disc herniations and stenosis.

c. Providers should take a thorough history on the first visit and carefully examine the patients for conditions that may predispose the patient to a more complex clinical course. Examples include the following: multiple medical diagnoses; prior history of physical or emotional abuse or chronic pain; multiple unresolved musculoskeletal conditions; depression or other psychological factors; fear-avoidant behavior; passive coping skills; limited range of motion; involvement in prior legal situations; and drug or opioid abuse etc. (American College of Occupational and Environmental Medicine [ACOEM] 2008; Carroll, 2008b,c,d). These patients may require multidisciplinary intervention to avoid the development of chronic pain, the use of unnecessary diagnostic testing, and prolonged treatment. Many of these can be identified using validated patient-completed screening tools. Patients with persistent neurologic complaints may also require a more progressive work-up or other treatment.

d. Health care providers are expected to discuss self-management of pain with their patients. Appropriate over-the-counter medication and ice or heat, if desired by the patient may initially be helpful. If pain is severe, as in some cases with ruptured discs, opioids may be prescribed for a short time period (such as three to seven days). This avoids the accumulation of unused opioids that may be available for others in the household to misuse and minimizes the likelihood of opioid dependence. Multiple repeat prescriptions for opioids should generally be avoided. If it is necessary to prescribe opioids for more than 14 days, the provider should do the following:

- i. repeat a thorough neurologic and neck examination to rule out a more serious diagnosis;
- ii. check the Physician's Drug Monitoring Program (PDMP);
- iii. consider urine drug screening; Refer to Chronic Pain Disorder Subchapter for drug screening requirements for Chronic Non-Cancer Pain Patients.
- iv. follow the patient closely; and
- v. consider a short screening questionnaire for abuse risk before prescribing.

e. All providers should emphasize return to activity with a detailed discussion describing exactly which activities should be performed and how often, as well as those

activities that should be avoided. The patient should identify functional goals at the initial visit which are specific to their needs. Examples include return to work; gardening, playing softball, driving, and computer use. In the absence of instability, complete bed rest or cervical immobilization is not advisable for this group of patients. The discussion of functional goals and current recommended activities should lead to return-to-work recommendations (Australian Acute Musculoskeletal Pain Guidelines Group, 2003).

f. Multiple studies assessing cost-effectiveness and outcomes recommend initial interventions should include education, non-opioid pain medication, and exercise or active therapy (Australian Acute Musculoskeletal Pain Guidelines Group, 2003). Spinal manipulation and supervised physical therapy, often including an assessment to determine the existence of directional preference, may also be appropriate for some patients. Most patients will recover with these interventions. Return to activity is important and should include return to work at appropriate physical duty levels, possibly with reduced work hours.

g. It is also appropriate to address smoking, as there is some evidence that patients who smoke respond less well to non-operative spine care and that quitting smoking results in greater improvement (Behrend, 2012).

h. Given the expected recovery rate for neck pain in the general population, the need for referral to physical, psychological or other therapy frequently depends on the presence of yellow flags and the need for further patient education to sustain activity participation. Yellow flags include psychosocial issues, such as problems with supervisors; presence of depression or anxiety; catastrophization; social withdrawal; fear-avoidance beliefs (belief that activity causing pain is harmful); or belief that passive therapy alone is curative. Injured workers may benefit from at least 2 visits with a physical therapist to re-enforce return to activity and education regarding exercise and activity. Further visits may be necessary if return to restricted duty cannot be arranged; and to reinforce education regarding exercise and activity. Patients with evidence of fear avoidant-behavior or other yellow flags are likely to require a different physical and/or psychosocial approach (Manca, 2007). Refer to Chronic Pain Medical Treatment Guidelines.

i. Many patients with musculoskeletal disorders also experience anxiety or depression. Using accepted screening tools periodically during patient visits can identify early psychological concerns. Cognitive behavioral therapy (CBT) is recommended for these patients and others who are not progressing as expected due to fear avoidance factors. CBT is as effective in populations that have disability as in those without disability (Ebrahim, 2012).

j. It is generally not appropriate to perform invasive procedures on a patient who reports only mild neck pain, for example 3 points or less on a 10-point Visual Analog Scale (VAS) measurement. However, pain reports vary greatly among individuals with the same condition. Therefore, in the presence of compromised physical function that correlates with physical exam findings, invasive procedures may be considered after compliance with recommended treatment for six weeks, or as otherwise listed in the guidelines. The following are examples of functional compromise: difficulty with activities of daily living, inability to participate in the

recommended active therapy, or lack of progress in job duty requirements.

k. As in the low back, cervical injections are unlikely to provide long-term relief. Spinal injections should not be done without prior imaging to establish the diagnosis. The risks versus benefits must be carefully weighed and discussed with the patient when these interventions are considered. Both the specialist referred to and the authorized provider must thoroughly discuss and document the possible complications, the limited short-term benefits, and the need for continuing engagement in active therapy.

l. Imaging is not recommended for at least six weeks after the initial injury unless it is necessary prior to a spinal injection or to rule out other acute diagnoses such as fracture, occult cancer, infection, upper extremity weakness, or signs of myelopathy. If a patient has persistent pain and imaging is deemed necessary, the ordering provider should document the following elements from face-to-face discussion with the patient:

i. the specific findings that the provider is trying to rule out with imaging and how the diagnostic test will influence treatment, and

ii. the lack of importance of “degenerative disease” alone due to its frequent occurrence in asymptomatic patients

m. Providers should remember that many medical terms used to describe radiographic findings or used as diagnostic terms engender fear and concern in patients. Unexplained concerns can lead patients to believe they have a significant pathological condition when, in fact, their condition is common and rarely leads to significant functional changes.

2. Neck Pain with Radicular and other Neurological Findings

a. Radicular findings from a herniated disc without progressive neurological findings and/or obvious significant continuing weakness may be treated according to the protocol in the previous section. This condition in the cervical spine is fairly common with a prevalence of 3.5/1000 (Casey, 2011). Many patients with isolated radicular signs may be expected to recover without surgery; however, those with suspected spinal instability and/or spinal cord compression are likely to need surgery (Bono, 2011; Jiang, 2011). Approximately 10-20 percent of patients will require surgery due to severity of symptoms or lack of improvement with initial treatment (Casey, 2011). Myelopathy or myeloradiculopathy is common among patients presenting with symptomatic cervical spondylolisthesis (Jiang, 2011). Therefore, the need for frequent detailed neurological exams in these patients is clear. Patients who have any signs of myelopathy or progressive neurological deficits should have expedited referral, magnetic resonance imaging (MRI) imaging, and may be appropriate for electrodiagnostic testing. Those with stable one- or two-level radicular findings without profound motor changes may be followed with conservative treatment for up to six weeks.

b. Any patient with neurologic findings of significant weakness or myelopathy, or significant functional impairment at 6 weeks should be considered for surgical referral since surgery should be performed before 12 weeks in order to allow the best outcome.

c. Most patients should exhibit the following signs of radiculopathy before invasive procedures are considered:

i. pain in the arms greater than in the neck which interferes with function, return to work and/or active therapy; and

ii. physical exam findings of abnormal reflexes, motor weakness or radicular sensation deficits; and

iii. findings on the MRI which indicate impingement of nerves or the spinal cord corresponding to reproducible physical exam findings

d. Spinal injections have not been shown to have long-term beneficial effects for most neck pain patients with or without radicular findings. Although complications are relatively rare, they can be catastrophic, particularly in the cervical spine. Thus, the cost-benefit versus risk ratio is small. Injections can contribute to the likelihood of lumbar osteoporotic fractures as the patient ages (Mandel, 2013) and appear to decrease the likelihood of successful surgery for spinal stenosis in the lumbar spine. This may also apply to the cervical spine. They may be used in uncommon cases when a patient continues to have measurable functional deficits at six weeks after not making progress despite compliance with conservative treatment or for those who are incapacitated after the initial treatment for herniated discs. Refer to Injections – Spinal Therapeutic and/or Injections – Other (including Radiofrequency).

e. Patients with objective findings causing functional impairment which does not improve may require surgical treatment. Herniated discs with continued neurologic findings interfering with activity or those with spondylolisthesis and radiculopathy or myelopathy frequently require surgery. Patients with symptomatic disc herniation have the best chance for a positive functional outcome if they receive surgery within three months of the onset of radicular pain and in most instances the results are excellent. All cases requiring surgical intervention require documentation of a discussion with the patient to clarify that functional goals such as anticipated ADL’s and work status align with patient expectations and goals. Refer to Therapeutic Procedures – Operative for details.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1631 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1119 (June 2014), LR 41:

§2005. Initial Diagnostic Procedures

A. The OWCA recommends the following diagnostic procedures be considered, at least initially the responsibility of the workers’ compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures, which should be utilized when initially diagnosing a work-related cervical complaint, are listed below.

1. History-taking and physical examination (Hx and PE). Generally accepted, well-established and widely used procedures that establish the basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures do not complement each other, the objective clinical findings should have preference. The medical records should reasonably document the following.

a. History of Present Injury. A detailed history, taken in temporal proximity to the time of injury, should primarily guide evaluation and treatment. The history should include:

i. mechanism of injury. This includes details of symptom onset and progression, including a detailed description and the position of the body before, during, and at the end of the incident. In the absence of a known specific incident, common positioning of the body during the work day and frequency of requirements such as lifting, pushing, and pulling should be included;

ii. description of pain. This should include location of pain, nature of symptoms, and alleviating/exacerbating factors (e.g. sleep positions, tolerance for neck flexion). Of particular importance, is whether raising the arm over the head alleviates radicular-type symptoms. The presence of pain at night or while at rest may be a sign of more extensive pathology. The history should include both the primary and secondary complaints (e.g., primary neck pain, secondary arm pain, headaches, and shoulder girdle complaints). Pain should be quantified on a Visual Analog Scale (VAS). The use of a patient-completed pain drawing, is highly recommended, especially during the first two weeks following injury, to assure that all work-related symptoms are being addressed. Screening the patient for fear-avoidance issues may be useful initially to guide treatment (Rainville, 2011);

iii. functional assessment. Functional ability should be assessed and documented at the beginning of treatment. Periodic assessment should be recorded throughout the course of care to follow the trajectory of recovery. In addition to being more relevant to recovery from neck pain, functional measures are likely to be more reliable over time than pain measures. Common assessment tools include Neck Pain and Disability Scale (NPAD), Copenhagen Neck Functional Disability Scale (CNFDS), and the Neck Disability Index (NDI) (Misailidou, 2010);

(a). patient-reported outcomes, whether of pain or function, are susceptible to a phenomenon called response shift. This refers to changes in self-evaluation which may accompany changes in health status. Patient self-reports may not coincide with objective measures of outcome, such as motor strength improvement, due to reconceptualization of the impact of pain on daily function and internal recalibration of pain scales (Schwartz, 2009). Response shift has potential to obscure treatment effects in clinical trials and clinical practice, and may lead to apparent discrepancies in patient-reported outcomes following treatment interventions. While methods of measuring and accounting for response shift are not yet fully developed, understanding that the phenomenon exists can help clinicians understand what is happening when some measures of patient progress appear inconsistent with other objective measures of progress;

iv. presence and distribution of upper and/or lower extremity numbness, paresthesias, or weakness, especially if precipitated by coughing or sneezing;

v. prior occupational and non-occupational injuries to the same area, including specific prior treatment, chronic or recurrent symptoms, and any functional limitations. Specific history regarding prior motor vehicle accidents may be helpful; and

vi. ability to perform job duties and activities of daily living (ADLs) including the ability to maintain balance and walk rapidly without difficulty.

b. Past History:

i. past medical history includes neoplasm, gout, arthritis, hypertension, diabetes, and fractures;

ii. review of systems includes symptoms of rheumatologic, neurologic, endocrine, neoplastic, infectious, and other systemic diseases;

iii. type 1 or type 2 diabetes. People with a body-mass index (BMI) greater than 30 may be at risk for the disease.

iv. smoking history- smoking appears to be related to low back pain and thus may affect neck pain and may predispose patients to opioid addiction (Behrend, 2012; Cheng, 2013);

v. medication use—prescription and non-prescription including vitamins and natural products;

vi. vocational and recreational pursuits, including military service; and

vii. history of depression, anxiety, or other psychiatric illness.

c. Physical Examination. Should include accepted tests and exam techniques applicable to the area being examined, including:

i. general inspection, including posture, stance and gait;

ii. visual inspection;

iii. palpation of spinous processes, facets, and muscles noting myofascial tightness, tenderness, and trigger points;

iv. cervical range of motion (ROM), preferably measured or quantified range of motion, quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may also be indicated. ROM should not be checked in acute trauma cases until fracture and instability have been ruled out on clinical examination, with or without radiographic evaluation. Patients with whiplash may be more likely to show decreased range of motion than asymptomatic patients (Dall'alba 2001);

v. examination of thoracic spine and shoulder;

vi. motor and sensory examination of the upper muscle groups with specific nerve root focus, as well as sensation to light touch, pin prick, temperature, position, and vibration. More than a 2 centimeter difference in the circumferential measurements of the two upper extremities may indicate chronic muscle wasting; motor and sensory changes may implicate a specific nerve root. Testing for hip flexion weakness may be a useful indicator of possible myelopathy;

vii. asymmetry of deep tendon reflexes may indicate pathology. Inverted reflexes (e.g. arm flexion or triceps tap) may indicate nerve root or spinal cord pathology at the tested level. Pathologic reflexes include wrist clonus, grasp reflex, and Hoffman's sign;

viii. assessment of gait, rapid walking, and balance;

ix. provocative tests for possible radiculopathy – The findings of provocative tests must be consistent with the patient's history, physical exam, and specific nerve root pathology. There is some evidence that Spurlings test, traction/neck distraction and Valsalva demonstrate high

specificity. The upper limb tension test (ULTT) should be done with finger and wrist extension. There is some evidence that a negative ULTT can be used to rule out radiculopathy (Rubinstein, 2007);

x. for providers trained in the technique, repeated end range testing may be done to establish the presence of a directional preference; and possible centralization (Refer to definition of directional preference in Therapeutic Procedures, Non-operative, neuromuscular testing);

xi. a combination of multiple physical exam test results is preferred because none are independently diagnostic.

d. Spinal Cord Evaluation. In cases where the mechanism of injury, history, or clinical presentation suggests a possible severe injury, additional evaluation is indicated. A full neurological examination for possible spinal cord injury may include the following:

i. sharp and light touch, deep pressure, temperature, and proprioceptive sensory function; with specific identification of the level of sensory and/or motor deficit;

ii. strength testing;

iii. anal sphincter tone and/or perianal sensation;

iv. presence of pathological reflexes of the upper and lower extremities; and

v. testing for hip flexion weakness may be a useful indicator of possible myelopathy.

vi. incomplete spinal cord injury syndromes include the following:

(a). - (b). ...

(c). central cord syndrome is characterized by sensory and motor disturbance of all limbs, often upper extremity more than lower, and loss of bowel and bladder function with preservation of perianal sensation. This is typically seen in elderly patients with a rigid spine following hyperextension injuries. Emergent surgery is not usually required;

(d). ...

vii. spinal cord lesions should be classified according to the American Spine Injury Association (ASIA) impairment scale;

ASIA IMPAIRMENT SCALE
<input type="checkbox"/> A= Complete: No motor or sensory function is preserved in the sacral segments S4-S5
<input type="checkbox"/> B= Incomplete: Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5
<input type="checkbox"/> C= Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3
<input type="checkbox"/> D= Incomplete: Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a grade of 3 or more
<input type="checkbox"/> E= Normal: Motor and sensory function are normal

viii. a worksheet detailing dermatomes and the muscle testing required is available from ASIA.

e. Soft Tissue Injury Evaluation. Soft tissue injuries are traumatic injuries to the muscles, ligaments, tendons, and/or connective tissue. The most common mechanism is sudden hyperextension and/or hyperflexion of the neck. Acceleration/deceleration on the lateral plane may also result in one of these syndromes. A true isolated cervical strain is not associated with focal neurological symptoms. The signs and pathophysiology of these injuries are not well

understood. Soft tissue injuries may include cervical strain, myofascial syndromes, somatic dysfunction, and fractures. The Quebec Classification is used to categorize soft tissue and more severe cervical injuries:

i. ...

ii. grade II—neck complaints with musculoskeletal signs, such as limited ROM. Includes muscle spasm related to soft tissue injury, whiplash, cervical sprain, cervicgia with headaches, and sprained cervical facet joints and ligaments;

iii. ...

iv. ...

f. Relationship to Work and Other Activity. This includes a statement of the probability that the illness or injury is medically work-related. If further information is necessary to determine work relatedness, the physician should clearly state what additional diagnostic studies or job information is required.

2. Radiographic Imaging. Radiographic Imaging of the cervical spine is a generally accepted, well-established, and widely used diagnostic procedure when specific indications based on history and/or physical examination are present. Basic X-ray views for the cervical spine are the anterior-posterior (AP), lateral, right and left obliques; odontoid; and swimmer's view. Computed tomography (CT) scans may be necessary to visualize C7 and odontoid in some patients. Lateral flexion and extension views are done to evaluate instability but may have a limited role in the acute setting. MRI is indicated when spinal cord injury is suspected. CT is necessary for suspected fracture/dislocation. The mechanism of injury and specific indications for the imaging should be listed on the request form to aid the radiologist and x-ray technician. Alert, non-intoxicated patients, who have isolated cervical complaints without palpable midline cervical tenderness, neurologic findings, or other acute or distracting injuries elsewhere in the body, may not require imaging. The following suggested indications are:

a. ...

b. age over 55 years;

c. suspicion of fracture, dislocation, instability, or objective evidence of neurologic deficit - Quebec Classification Grades III and IV;

d. ...

e. localized pain, fever, constitutional symptoms, or history or exam suggestive of intravenous drug abuse, prolonged steroid use, or osteomyelitis;

f. suspected lesion in the cervical spine due to tumor or systemic illness, such as a rheumatic/rheumatoid disorder or endocrinopathy;

g. past medical history suggestive of pre-existing spinal disease, osteoporosis, spinal instrumentation, or cancer;

h. optionally, (radiographic imaging) prior to any manipulative treatment.

3. Laboratory Testing. Laboratory tests are generally accepted, well-established and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, or underlying rheumatologic disorder, or connective tissue disorder based on history and/or physical examination. Laboratory tests can provide useful

diagnostic information. Furthermore, they may assist the provider in determining the best course of treatment for the patient. Tests include, but are not limited to:

- a. complete blood count (CBC) with differential, which can detect infection, blood dyscrasias, and medication side effects;
- b. blood-glucose level, which can be used to detect evidence of Type 1 or Type 2 diabetes.
- c. erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), anti-nuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP), which can be used to detect evidence of a rheumatologic disorder, infection, or connective tissue disorder;
- d. serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase, which can detect metabolic bone disease; and
- e. liver and kidney function, which may be performed for prolonged anti-inflammatory use, or with use of other medications requiring monitoring.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1632 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1120 (June 2014), LR 41:

§2007. Follow-Up Diagnostic Imaging and Testing Procedures

A. One diagnostic imaging or testing procedure may provide the same or distinctive information as does another procedure. Therefore, prudent choice of a single diagnostic procedure, a complement of procedures, or a sequence of procedures, will optimize diagnostic accuracy, maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients. All imaging and testing procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis.

B. Clinical information obtained by current history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results. Clinical updates must demonstrate the patient's current status to document the need for diagnostic testing or additional treatment. A brief history, changes in clinical findings such as orthopedic and neurological tests, and measurements of function with emphasis on the current, specific physical limitations will be important when seeking approval of future care. The emphasis of the medical treatment schedule are that the determination of the need to continue treatment is based on functional improvement, and that the patient's ability (current capacity) to return to work is needed to assist in disability management.

C. MRI imaging of the cervical spine generally renders the most information. Magnetic resonance imaging (MRI), myelography, or Computed Axial Tomography (CT) scanning following myelography, and other imaging and testing procedures may provide useful information for many spinal disorders. Practitioners should be aware of the radiation doses associated with various procedures and provide appropriate warnings to patients. Unnecessary CT scans or X-rays increase the lifetime risk of cancer death (Hendricks, 2011). When a diagnostic procedure, in

conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging Studies. These are generally accepted, well-established, and widely used diagnostic procedures. In the absence of myelopathy or progressive neurological changes, imaging usually is not appropriate until conservative therapy has been tried and has failed. Six to eight weeks of treatment is frequently an adequate period of time before an imaging procedure is in order, but the clinician should use judgment in this regard. When indicated, imaging studies can be utilized for further evaluation of the cervical spine, based on the mechanism of injury, symptoms, and patient history. When the findings of the diagnostic imaging and testing procedures are not consistent with the clinical examination, a careful neurological exam may be appropriate.

a. There is some evidence that the majority of workers over 60 show evidence of disc degeneration and posterior disc protrusions are present in the majority of asymptomatic workers over 40 years of age (Matsumoto, 1998). There is also some evidence that degenerative changes occurring over time in asymptomatic workers effect the cervical and lumbar spine equally (Matsumoto, 2013). Small herniations and protrusions are often not pain generators, although small foraminal disc herniations are likely to compress the nerve root and require surgical removal. Moderate reduction in the cross-sectional area of the spinal cord may be seen without myelopathy in the majority of patients older than 40; therefore, clinical correlation is required (Ishimoto, 2013).

b. The studies below are listed in frequency of use, not importance.

i. Magnetic Resonance Imaging (MRI). The imaging study of choice for most abnormalities of the cervical spine. MRI is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. MRI should be performed immediately if there is a question of infection or metastatic disease with cord compression. MRI is contraindicated in patients with certain implanted devices; however, MRI scanners compatible with pacemakers are now available.

(a). In general, conventional full-size, high field magnet 1.5 tesla MRI provides better resolution and is preferred. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist.

ii. - ii.(b). ...

(c). Contrast MRI: Usually required for those with prior cervical surgery, possible infection, possible malignancy, or tumor.

iii. Computed Axial Tomography (CT). CT scans provide excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic evaluation. It may sometimes be done as a complement to MRI scanning to better delineate bony osteophyte formation in the neural foramen. CT is usually utilized for suspected cervical spine fracture in a patient with negative plain films, or to further delineate a cervical fracture. CT scanning is also quite useful for congenital anomalies at the skull base and at the C1-2 levels. Instrument-scatter reduction software provides better resolution when metallic artifact is of concern. Unnecessary CT scanning should be avoided due to the radiation exposure contributing to cancer risk.

iv. Myelography. This is the injection of radiopaque material into the spinal subarachnoid space, with x-rays then taken to define anatomy. It may be used as a pre-surgical diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures. The use of small needles and a less toxic, water-soluble, nonionic contrast is recommended. Myelography is an invasive procedure with numerous complications, including nausea, vomiting, headache, convulsion, arachnoiditis, cerebrospinal fluid leak (CSF) leakage, allergic reactions, bleeding, and infection. Therefore, myelography should be considered only in the following instances:

(a). when CT and MRI are unavailable;

(b). when CT or MRI is contraindicated such as for morbidly obese patients or those who have undergone multiple surgical procedures; and when other tests prove non-diagnostic in the surgical candidate.

v. CT Myelogram. This test provides more detailed information about relationships between neural elements and surrounding anatomy and is appropriate in patients with multiple prior operations, tumorous conditions, or those that cannot have MRIs due to implants, etc.

vi. Single Photon Emission Computerized Tomography (SPECT). A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans and CT scans in looking for facet joint pathology.

vii. Lineal Tomography. This is infrequently used, yet may be helpful in the evaluation of bone surfaces, bony fusion, or pseudarthrosis.

viii. Bone Scan (Radioisotope Bone Scanning). Bone scanning is generally accepted, well-established, and widely used. It is more sensitive but less specific than MRI. ^{99m}Techetium diphosphonate uptake reflects osteoblastic activity and may be useful in diagnosing metastatic/primary bone tumors, occult or stress fractures, osteomyelitis, infection, and other inflammatory lesions, but it cannot distinguish between these conditions.

ix. Other Radioisotope Scanning. Indium and gallium scans are generally accepted, well-established, widely used procedures, and often used to diagnose lesions seen on other diagnostic imaging studies. ⁶⁷Gallium citrate scans are used to localize tumors, infections, and abscesses.

¹¹¹Indium-labeled leukocyte scanning is utilized for localizing infection or inflammation and is usually not used for the cervical spine.

x. Dynamic [Digital] Fluoroscopy. Dynamic [digital] fluoroscopy of the cervical spine measures the motion of intervertebral segments using a videofluoroscopy unit to capture images as the subject performs cervical flexion and extension, storing the anatomic motion of the spine in a computer. Dynamic fluoroscopy may be used in the acute trauma setting to evaluate the cervical spine. Its superiority over MRI has not been established. If performed, full visualization of the cervical spine (C1-T1), in accordance with Initial Diagnostic Procedures-Imaging, should be accomplished prior to the procedure. In some rare cases in the post-acute setting, Dynamic [Digital] Fluoroscopy may be used but is primarily an investigational tool and therefore requires prior authorization in the post-acute setting. No studies have yet demonstrated predictive value in terms of standard operative and non-operative therapeutic outcomes.

xi. Indications for Repeat Imaging or Testing:

(a). progressive neurological change; or

(b). onset of myelopathy; or

(c). approved surgical intervention where most recent scan is more than 12 months prior.

2. - 2.a. ...

i. Electromyography (EMG) and Nerve Conduction Studies (NCS). These are generally accepted, well-established, and widely used diagnostic procedures. EMG and NCS, when performed and interpreted by a trained physician, may be useful for patients with suspected neural involvement whose symptoms are persistent or unresponsive to initial conservative treatments. They are used to differentiate peripheral neural deficits from radicular and spinal cord neural deficits and to rule out concomitant myopathy. However, F-Wave Latencies are not diagnostic for radiculopathy.

(a). In general, EMG and NCS are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electrodiagnostic studies may provide useful, correlative neuropathophysiological information that would be otherwise unobtainable from the radiologic studies discussed above and can assist in treatment decisions, such as the need for surgery.

(b). Indications for Repeat EMG and NCS

(i). progressive neurological change; or

(ii). onset of myelopathy; or

(iii). approved surgical intervention where most recent scan is more than 12 months prior.

ii. Portable Automated Electrodiagnostic Device (also known as Surface EMG). This is not a substitute for conventional diagnostic testing in clinical decision-making and therefore, is not recommended.

iii. Somatosensory Evoked Potential (SSEP). Useful for the evaluation of myelopathy. It is not recommended to identify radiculopathy.

iv. Current Perception Threshold Evaluation (CPT). May be useful as a screening tool, but its diagnostic efficacy in the evaluation of cervical spine pain has not been determined. Therefore, CPT is not recommended as a diagnostic tool.

b. - b.i ...

ii. Indications. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. All spinal injections should be preceded by either an MRI or a CT scan. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms. Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be primary pain generators. Patients should not receive all of the diagnostic blocks listed merely in an attempt to identify 100 percent of the pain generators.

iii. - iv. ...

v. Complications. General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningeal abscess. Severe complications are remote but can include spinal cord damage, quadriplegia, and/or death. Injections at a C2-C3 level frequently cause temporary neuritis with ataxia.

vi. Contraindications

vi.(a) - vii.(d)(ii). ...

c. Psychological/Psychosocial Evaluation. Generally accepted and well-established diagnostic procedures with selective use in the acute cervical spine injury population and more widespread use in sub-acute and chronic-cervical spine populations.

i. These diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for pre-operative evaluation as well as a possible predictive value for post-operative response. Psychological/psychosocial measures have been shown to have predictive value for post-operative response. Psychological testing should provide differentiation between pre-existing depression versus injury-caused depression, as well as post-traumatic stress disorder. Psychological testing should incorporate measures that have been shown empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

ii. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

(a.) - (b). ...

(c.) leisure activities;

(d.) current perception of the medical system;

(e.) results of current treatment;

(f.) perceived locus of control; and

(g.) childhood history, including history of childhood psychological trauma, abuse and family history of disability.

iii. Psychological/psychosocial evaluations consist of two components, clinical interview and psychological testing. This information should provide clinicians with a better understanding of the patient, thus allowing for more

effective rehabilitation. The evaluation will determine the need for further psychosocial interventions, and in those cases, a Diagnostic Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. A licensed psychologist or psychiatric MD/DO credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided. When issues of chronic pain are identified, the evaluation should be more extensive and follow testing procedures as outlined in the Chronic Pain Disorder Medical Treatment Guidelines.

(a). Frequency: One-time visit for evaluation. If psychometric testing is indicated as a portion of the initial evaluation, time for such testing should not exceed an additional seven hours of professional time.

iv. Unless objective medical findings explain symptom persistence, any patient who has not returned to work by six months will be required to undergo a full Psychosocial Evaluation by a Psychiatrist or licensed Psychologist. (see Chronic Pain Disorder subchapter, Section 2109.2 for details)

d. Provocation Discography

i. Description. Discography remains extremely controversial, carries a high risk when performed in the cervical spine, and findings are of unclear significance due to false positives and the general lack of indications for cervical surgery in patients without radicular findings (Randhawa, 2013). Therefore, it is rarely indicated. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, preconditions, special considerations, procedures, reporting requirements, and results, are carefully and specifically followed. Results should be interpreted judiciously. Fewer studies have been published on cervical and thoracic discography than on lumbar discography

ii. Indications. Discography may be performed in specific cases when a single level fusion or artificial disc replacement is being considered for a patient with isolated one level axial pain who meets all of the other requirements for the procedure; and when a patient has a history of functionally limiting, unremitting cervical pain of greater than four months duration, with or without arm pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.

(a). Discography may prove useful for the evaluation of the pre-surgical spine, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.

(b). Discography may show disc degeneration and annular disruption in the absence of cervical pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential neck pain. Because

patients with mild neck pain should not be considered for invasive treatment, discography should not be performed on these patients. The presence of an annular tear does not necessarily identify the tear as a pain generator.

(c). Discography is not useful in previously operated discs. Discography may prove useful in evaluating the number of cervical spine levels that might require fusion. CT Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

iii. Preconditions for provocation discography include all of the following:

(a). - (d). ...

iv. Complications. Include, but are not limited to, discitis, nerve damage, retropharyngeal abscess, chemical meningitis, pain exacerbation, and anaphylaxis. Therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

v. Contraindications. Include active infection of any type or continuing antibiotic treatment for infection; and/or bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or presence of clinical myelopathy; and/or effacement of the cord, thecal sac or circumferential absence of epidural fat; and known allergic reactions.

vi. Special Considerations

(a). - (g). ...

vii. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of disc morphology and the pain response. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

(a). When discography is performed to identify the source of a patient's neck pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

(b). Caution should be used when interpreting results from discography. One study using asymptomatic volunteers reported pain in the majority of discs injected, but no subjects reported pain exceeding 6/10 on a pain scale in a normal disc.

(c). Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

(i). grade 0 = normal nucleus;

(ii). grade 1 = annular tear confined to inner one-third of annulus fibrosis;

(iii). grade 2 = annular tear extending to the middle third of the annulus fibrosis;

(iv). grade 3 = annular tear extending to the outer one-third of the annulus fibrosis;

(v). grade 4 = a grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference;

(vi). grade 5 = full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

(d). Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society Guidelines (ISIS). The report must include the level of concordance for neck and arm pain separately using a 10-point VAS, or similar quantitative assessment. It should be noted that the change in the VAS score before and after provocation is more important than the number reported.

(e). The diagnosis of discogenic pain is less likely when there are more discs with dissimilar pain and fewer with no pain. At least two discs with no pain on stimulation and one disc with concordant pain registering at least 7 on a 10-point VAS or equivalent should be present to qualify for a diagnosis of discogenic pain. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

viii. Time parameters for provocation discography are as follows:

(a). Frequency: one time only;

(b). Maximum: repeat discography is rarely indicated.

e. Thermography: An accepted and established procedure, but it has no use as a diagnostic test for neck pain. It may be used to diagnose complex regional pain disorders. Refer to the OWCA's Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. Special Tests. These are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and physical work demand classifications and tolerance. The procedures in this subsection are listed in alphabetical order, not by importance.

a. Computer-Enhanced Evaluations. These may include isotonic, isometric, isokinetic, and/or isoinertial measurement of movement; range of motion (ROM); endurance; or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment, and demonstrated motivation. These evaluations should not be used alone to determine return-to-work restrictions.

i. Frequency: One time for evaluation, Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. - b.(iii). ...

c. Jobsite Evaluation. A comprehensive analysis of the physical, mental, and sensory components of a specific job. These components may include, but are not limited to: postural tolerance (static and dynamic); aerobic requirements; ROM; torque/force; lifting/carrying; cognitive demands; social interactions; visual perception; sensation; coordination; environmental factors of a job; repetitiveness; and essential job functions.

i. - ii.(b). ...

(c). to provide a detailed description of the physical and cognitive job requirements;

(d). - (e). ...

iii. Frequency: one time with one to two additional visits as needed for follow-up per jobsite.

d. Vocational Assessment. If the injury is such that the practitioner can easily determine that the worker will be unable to return to his/her previous occupation, then vocational assessment at that time may aid in the overall medical management and assessment of the patient. The physician may decide that the patient is unable to return to the previous occupation prior to the declaration of Maximum Medical Improvement (MMI).

i. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. The physician should have identified the expected permanent limitation(s) prior to the assessment. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

ii. Frequency: one time with additional visits as needed for follow-up.

e. Work Tolerance Screening. A determination of an individual's tolerance for performing a specific job as based on a job activity or task and is generally preferable to a full FCE. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular fitness, physical fitness, and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential.

i. Frequency: one time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

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§2009. Therapeutic Procedures—Non-Operative

A. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these four important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to Return to Work for detailed information.

C. - C.1.d. ...

D. Third, providers should provide and document patient education. Before invasive treatment takes place, the patient should be able to clearly articulate the goals of the intervention, the general side effects and associated risks, and the patient's agreement with the expected treatment plan.

E. Last, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. ...

G. The following procedures are listed in alphabetical order.

1. Acupuncture

a. When acupuncture has been studied in randomized clinical trials, it is often compared with sham acupuncture and/or no acupuncture (usual care). The differences between true acupuncture and usual care have been moderate, but clinically important. These differences can be partitioned into two components: non-specific effects and specific effects. Non-specific effects include patient beliefs and expectations, attention from the acupuncturist, administration of acupuncture in a relaxing setting, and other components of what is often called the placebo effect. Specific effects refer to any additional effects which occur in the same setting of expectations and attention, but they are attributable to the penetration of the skin in the specific, classic acupuncture points on the surface of the body by the needles themselves.

b. There is good evidence that acupuncture, true or sham, is superior to usual care for the reduction of disability and pain in patients with chronic nonspecific low back pain, and that true and sham acupuncture are likely to be equally effective (Cherkin, 2009). A sham procedure is a non-therapeutic procedure that appears similar to the patient as the purported therapeutic procedure being tested. In most controlled studies, sham and classic acupuncture have produced similar effects. However, the sham controlled studies have shown consistent advantages of both true and sham acupuncture over no acupuncture when the studies have included a third comparison group that was randomized to usual medical care. Having this third comparison group has been advantageous in the interpretation of the non-specific effects of acupuncture, since the third comparison group controls for some influences on study outcome. These influences include more frequent contact with providers, the natural history of the condition, regression to the mean, the effect of being observed in a clinical trial, and, if the follow-up observations are done consistently in all three treatment groups, for biased reporting of outcomes. Controlling for these factors enables researchers to more closely estimate the contextual and personal interactive effects of acupuncture as it is generally practiced.

c. Because the sham acupuncture interventions in the clinical trials are generally done by trained acupuncturists, and not by totally untrained personnel, the sham acupuncture interventions may include some of the effects of true acupuncture (Dincer, 2003), much as a partial agonist of a drug may produce some of the effects of the actual drug. For example, a sham procedure involving toothpicks rather than acupuncture needles may stimulate cutaneous afferents in spite of not penetrating the skin, much as a neurological sensory examination may test nociceptor function without skin penetration. To the extent that afferent stimulation is part of the mechanism of action of acupuncture, interpreting the sham results as purely a control group would lead to an underestimation of the analgesic effects of acupuncture. Thus we consider in our analysis that "sham" or non-classic acupuncture may have a positive clinical effect when compared to usual care.

d. Clinical trials of acupuncture typically enroll participants who are interested in acupuncture, and who may respond to some of the non-specific aspects of the intervention more than would be expected of patients who have no interest in or desire for acupuncture. The non-

specific effects of acupuncture may not be produced in patients who have no wish to be referred for it.

e. There is good evidence there is a likely, small clinical benefit of acupuncture for acute low back pain and it may be considered an alternative for some patients (Lee, 2013). There is good evidence that both acupuncture and sham acupuncture are superior to usual care without acupuncture for moderate short-term and mild long-term alleviation of low back pain, neck pain, and the pain of joint osteoarthritis (Brinkhaus, 2006; Ernst, 2011; Haake, 2007). Another study provides good evidence that true acupuncture at traditional medians is marginally better than sham acupuncture with blunt needles in reducing pain, but effects on disability are unclear (Cho, 2013). In these studies 5-15 treatments were provided. Comparisons of acupuncture and sham acupuncture have been inconsistent, and the advantage of true over sham acupuncture has been small in relation to the advantage of sham over no acupuncture.

f. Acupuncture is recommended for subacute or chronic pain patients who are trying to increase function and/or decrease medication usage and have an expressed interest in this modality. It is also recommended for subacute or acute low back pain for patients who cannot tolerate nonsteroidal anti-inflammatory drugs (NSAIDs) or other medications. Acupuncture is not the same procedure as dry needling for coding purposes; however, some acupuncturists may use acupuncture treatment for myofascial trigger points. Dry needling is performed specifically on myofascial trigger points. Refer to Dry Needling Treatment.

g. Credentialed practitioners with experience in evaluation and treatment of chronic pain patients must perform acupuncture evaluations. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. It may be used when pain medication is reduced or not tolerated; as an adjunct to physical rehabilitation and surgical intervention; and/or as part of multidisciplinary treatment to hasten the return of functional activity. Acupuncture must be performed by practitioners with the appropriate credentials in accordance with state and other applicable regulations. Therefore, if not otherwise within their professional scope of practice and licensure, those performing acupuncture must have the appropriate credentials, such as L.A.c., R.A.c, or Dipl. Ac.

h. Acupuncture: This is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture has a variety of possible physiologic actions, but their relevance to the clinical response is speculative. For example, one crossover trial measured increasing palmar blood flow and increased nitric oxide synthase activity in arms which had had acupuncture, but this observation may have no bearing on actual analgesic effects (Tsuchiya, 2007).

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

i. Acupuncture with Electrical Stimulation. The use of electrical current (micro-ampere or milli-ampere) on

the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. ...

j. Other Acupuncture Modalities. Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Therapeutic Exercise, Massage – Manual or Mechanical, and Superficial Heat and Cold Therapy (excluding Infrared Therapy) for a description of these adjunctive acupuncture modalities and time frames.

k. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation. Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

i. Time to Produce Effect: Three to six treatments.

ii. Frequency: one to three times per week.

iii. Optimum Duration: one to two months.

iv. Maximum Duration: 15 treatments.

v. Any of the above acupuncture treatments may extend longer if objective functional gains can be documented and when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 15 treatments must be documented with respect to need and the ability to facilitate positive symptomatic and functional gains. Such care should be re-evaluated and documented with each series of treatments. All treatments should be accompanied by active therapy.

2. Biofeedback. A form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Stress-related psycho-physiological reactions may arise as a reaction to organic pain and in some cases may cause pain. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorily, or tactilely, with coaching by a biofeedback specialist. There is good evidence that biofeedback or relaxation therapy is equal in effect to cognitive behavioral therapy for chronic low back pain (Hoffman, 2007).

a. Indications for biofeedback include cases of musculoskeletal injury, in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of pain, anxiety, panic, anger or emotional distress, opioid withdrawal, insomnia/sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized for relaxation training. Mental health professionals may also utilize it as a component of psychotherapy, where biofeedback and other behavioral

techniques are integrated with psychotherapeutic interventions. Biofeedback is often used in conjunction with physical therapy or medical treatment.

b. Recognized types of biofeedback include the following:

i. electromyogram (EMG): used for self-management of pain and stress reactions involving muscle tension.

ii. skin temperature: used for self-management of pain and stress reactions, especially vascular headaches.

iii. respiration feedback (RFB): used for self-management of pain and stress reactions via breathing control.

iv. respiratory sinus arrhythmia (RSA): used for self-management of pain and stress reactions via synchronous control of heart rate and respiration. Respiratory sinus arrhythmia is a benign phenomenon that consists of a small rise in heart rate during inhalation, and a corresponding decrease during exhalation. This phenomenon has been observed in meditators and athletes, and is thought to be a psycho-physiological indicator of health.

v. heart rate variability (HRV): used for self-management of stress via managing cardiac reactivity.

vi. electrodermal response (EDR): used for self-management of stress involving palmar sweating or galvanic skin response.

vii. electroencephalograph (EEG, QEEG): used for self-management of various psychological states by controlling brainwaves.

c. The goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training should be motivated to learn and practice biofeedback and self-regulation techniques. In the course of biofeedback treatment, patient stressors are discussed and self-management strategies are devised. If the patient has not been previously evaluated, a psychological evaluation should be performed prior to beginning biofeedback treatment for chronic pain. The psychological evaluation may reveal cognitive difficulties, belief system conflicts, somatic delusions, secondary gain issues, hypochondriasis, and possible biases in patient self-reports, which can affect biofeedback. Home practice of skills is often helpful for mastery and may be facilitated by the use of home training tapes.

d. Psychologists or psychiatrists who provide psycho-physiological therapy, which integrates biofeedback with psychotherapy, should be either Biofeedback Certification International Alliance (BCIA) certified or practicing within the scope of their training. All non-licensed health care providers of biofeedback for chronic pain patients must be BCIA certified and shall have their biofeedback treatment plan approved by the authorized treating psychologist or psychiatrist. Biofeedback treatment must be done in conjunction with the patient's psychosocial intervention. Biofeedback may also be provided by health care providers who follow a set treatment and educational protocol. Such treatment may utilize standardized material or relaxation tapes.

e. Timing/Frequency/Duration

i. Time to Produce Effect: three to four sessions.

ii. Frequency: one to two times per week.

iii. Optimum Duration: six to eight sessions.

iv. Maximum Duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic and functional gains.

3. Injections—Spinal Therapeutic

a. General Discussion and Indications

i. Description. Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. Therapeutic injections should only be used after diagnostic injections and / or imaging studies have established. Injections are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to.

ii. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to Therapy-Active). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active range of motion (ROM), strength, and stability. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings

iii. Special Requirements for Spinal Therapeutic Injections. For all injections (excluding trigger point), multi-planar fluoroscopic guidance during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, neurology, surgery, or psychiatry. The practitioner should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. They must also be knowledgeable in radiation safety.

iv. Complications. General complications of spinal injections may include transient neurapraxia, local pain, nerve injury, infection, headache, urinary retention, and vasovagal effects, epidural hematoma, permanent neurologic damage, dural perforation, cerebrospinal fluid (CSF) leakage, and/or spinal meningeal abscess may also occur. Permanent paresis, anaphylaxis, arachnoiditis, and death have been rarely reported with the use of epidural steroids. With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary-adrenal axis lasting between one and three months.

v. Contraindications. Absolute contraindications to therapeutic injections include: bacterial infection – systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy.

vi. Relative contraindications to therapeutic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus for steroid injections, and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to American Society of Regional Anesthesia for anticoagulation guidelines.

b. Cervical Epidural Steroid Injection (ESI)

i. Description. Cervical Epidural steroid injections are injections of corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation in the acute or sub-acute phases of injury, restoring range of motion and, thereby, facilitating progress in more active treatment programs.

ii. Needle Placement. Multi-planar fluoroscopic imaging is required for all epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural. Permanent images are required to verify needle placement.

iii. Indications

(a). - (c). ...

iv. Time/Frequency/Duration

(a). - (b). ...

(i). Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. If the first injection does not provide a diagnostic response with temporary and sustained pain relief (at least two to six weeks) substantiated by accepted pain scales (i.e., 50 percent pain reduction as measured by tools such as VAS), and improvement in function, similar injections should not be repeated.

(c). Optimal Duration. Usually one to three injection(s), over a period of six months depending upon each patient's response and functional gain.

(d). Maximum Duration. Two sessions consisting of up to three injections each may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

c. Intradiscal Steroid Therapy

i. Intradiscal steroid therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic low back pain. There is no support for its use in the cervical spine and its use is not recommended.

d. Occipital Nerve Block

i. - iii. ...

iv. Timing/Frequency/Duration

(a). Time to Produce Effect: approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(b). Optimal Duration: one to three sessions for each nerve.

(c). Maximum Duration: continue up to three injections if progressive symptomatic and functional improvement can be documented.

e. Transforaminal Injection with Etanercept

i. Description. Transforaminal injection with a tumor necrosis factor alpha inhibitor is thought to decrease the inflammatory agents which may be associated with the pathophysiology of lumbar radicular pain from a herniated disc.

ii. It is not recommended due to the results of a study which showed no advantage over steroids or saline injections (Cohen, 2012).

f. Zygapophyseal (Facet) Injection

i. Description. A generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. There is conflicting evidence to support long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

ii. Indications. Patients with pain suspected to be facet in origin based on exam findings and affecting activity; or patients who have refused a rhizotomy or patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

iii. Timing/Frequency/Duration

(a). Time to produce effect: up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

(b). Frequency: 1 injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

(i). Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

(c). Optimum duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

(d). Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

4. Injections—Other including Radio Frequency. The following are in alphabetical order:

a. Botulinum Toxin Injections

i. Description. Used to temporarily weaken or paralyze muscles. These injections may reduce muscle pain in conditions associated with spasticity or dystonia. Neutralizing antibodies develop in at least 4 percent of

patients treated with botulinum toxin type A, rendering it ineffective. Several antigenic types of botulinum toxin have been described. Botulinum toxin type B, first approved by the Food and Drug Administration (FDA) in 2001, is similar pharmacologically to botulinum toxin type A. It appears to be effective in patients who have become resistant to the type A toxin. The immune responses to botulinum toxins type A and B are not cross-reactive, allowing type B toxin to be used when type A action is blocked by antibody. Experimental work with healthy human volunteers suggests that muscle paralysis from type B toxin is not as complete or as long lasting as that resulting from type A.

(a). The duration of treatment effect of botulinum toxin type B for cervical dystonia has been estimated to be 12 to 16 weeks. Electromyography (EMG) needle guidance may permit more precise delivery of botulinum toxin to the target area. There is strong evidence that botulinum toxin A has objective and symptomatic benefits over placebo for cervical dystonia (Costa, 2005).

(b). Botulinum Injections are no longer generally recommended for cervicogenic or other headaches based on good evidence of lack of effect ([Cochrane] Langevin, 2011; Linde, 2011, Aurora, 2011). There is good evidence that botulinum toxin is not more effective than placebo for reducing the frequency of episodic migraines (Shuhendler, 2009). It may be considered in a very small subset of patients with chronic migraines 12–15 days/month who have failed all other conservative treatment, including trials of at least three drug classes, and who have committed to any life style changes related to headache triggers (Jackson, 2012a, b).

ii. Indications. For conditions which produce chronic spasticity or dystonia. There should be evidence of limited range-of-motion prior to the injection. Not recommended for cervicogenic headaches. Refer to the OWCA's Traumatic Brain Injury (TBI) Medical Treatment Guidelines for indications regarding headache.

(a). There is insufficient evidence to support its use for longer-term pain relief of other myofascial trigger points and it is likely to cause muscle weakness or atrophy if used repeatedly (Ferrante, 2005; Gobel, 2006; Porta, 2000). Examples of such consequences include subacromial impingement, as the stabilizers of the shoulder are weakened by repeated injections of trigger points in the upper trapezii. Therefore, it is not recommended for use for other myofascial trigger points (Abbott, 2007).

iii. Complications. There is good evidence that cervical botulinum toxin A injections cause transient dysphagia and neck weakness. Allergic reaction to medications, dry mouth and vocal hoarseness may also occur ([Cochrane] Costa, 2005). Rare systemic effects include flu-like syndrome, and weakening of distant muscle. There is an increased risk of systemic effects in patients with motor neuropathy or disorders of the neuromuscular junction.

(a). Time to Produce Effect: 24 to 72 hours post injection with peak effect by four to six weeks.

(b). Frequency: no less than three months between re-administration. Patients should be reassessed after each injection session for an 80 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement for three months. A positive result would include a return to base line function, return to

increased work duties, and measurable improvement in physical activity goals including return to baseline after an exacerbation.

(c). Optimum Duration: three to four months.

(d). Maximum Duration: currently unknown.

Repeat injections should be based upon functional improvement and therefore used sparingly in order to avoid development of antibodies that might render future injections ineffective. In most cases, not more than four injections are appropriate due to accompanying muscle atrophy.

b. Epiduroscopy and Epidural Lysis of Adhesions: is not recommended in the cervical spine secondary to the potential for dural puncture, hematoma, and spinal cord.

c. Prolotherapy: Also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and phenol, into the ligamentous structures of the neck. Its proponents claim that the inflammatory response to the injections will recruit cytokine growth factors involved in the proliferation of connective tissue, stabilizing the ligaments of the neck when these structures have been damaged by mechanical insults.

i. There is good evidence that prolotherapy alone is not an effective treatment for chronic low back pain ([Cochrane] Dagenais, 2007). Similarly, the use of prolotherapy for cervical pain is generally not recommended.

d. Radio Frequency Ablation—Dorsal Nerve Root Ablation: Due to the combination of adverse side effects, time-limited effectiveness, and mixed study results, this treatment is not recommended. Refer to the Chronic Pain Disorder Medical Treatment Guidelines.

e. Radio Frequency (RF) Denervation—Medial Branch Neurotomy/Facet Rhizotomy:

i. Description. A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used.

(a). There is good evidence to support this procedure in the cervical spine but benefits beyond one year are not yet established. Radio-frequency medial branch neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe using fluoroscopic guidance is required because the maximum effective diameter of the device is a 5 by 8 millimeter oval. Permanent images should be recorded to verify placement of the device.

ii. Needle Placement. Multi-planar fluoroscopic imaging is required for all injections. Injection of contrast dye to assure correct needle placement is required to verify the flow of medication. Permanent images are required to verify needle placement.

iii. Indications. Those patients with proven, significant, facetogenic pain. This procedure is not recommended for patients with multiple pain generators or involvement of more than three levels of medial branch nerves.

(a). Individuals should have met the following indications: pain of well-documented facet origin, unresponsive to active and/or passive therapy, manual therapy, and in which a psychosocial evaluation has been performed. It is generally recommended that this procedure

not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Therapy-Active).

(b). All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks-using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used.

(c). In almost all cases this will mean a reduction of pain to one or two on the VAS 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

(d). A separate comparative block may be performed on a different date to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

iv. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

v. Post-Procedure Therapy. Active therapy. Implementation of a gentle aerobic reconditioning program within the first post-procedure week recommended, barring complications. Instruction and participation in a long-term home-based program of ROM, cervical, scapular, and thoracic strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

vi. Requirements for Repeat Radiofrequency Medial Branch Neurotomy (or additional-level RF Neurotomies). In some cases pain may recur. Successful RF Neurotomy usually provides from six to eighteen months of relief.

(a). Before a repeat RF Neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

f. Transdiscal Biacuplasty. A cooled radiofrequency procedure intended to coagulate fissures in the disc and surrounding nerves which could be pain generators. It is not recommended due to lack of published data demonstrating effectiveness (ISIS, 2013).

g. Trigger Point Injections

i. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of injection of local anesthetic, with or without corticosteroid, into highly localized, extremely sensitive

bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities.

(a). There is conflicting evidence regarding the benefit of trigger point injections ([Cochrane] Staal, 2008). A truly blinded study comparing dry needle treatment of trigger points is not feasible. (See Passive Therapy – Dry Needling). There is no evidence that injection of medications improves the results of trigger-point injections ([Cochrane] Staal, 2008). Needling alone may account for some of the therapeutic response.

(b). There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

ii. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as active therapy programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

(a). Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six week time frame. However, trigger point injections may be occasionally effective when utilized in the patient with immediate, acute onset of neck pain.

iii. Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, penetration of viscera, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

iv. Timing/Frequency/Duration

(a). Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia.

(b). Frequency: Weekly. Suggest no more than 4 injection sites per session per week to avoid significant post-injection soreness.

(c). Optimum duration: Four Weeks.

(d). Maximum duration: Eight weeks. Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

5. **Interdisciplinary Rehabilitation Programs.** This is the gold standard of treatment for individuals with low back pain who have not responded to less intensive modes of treatment. There is good evidence that interdisciplinary programs which include screening for psychological issues, identification of fear-avoidance beliefs and treatment barriers, and establishment of individual functional and work goals will improve function and decrease disability (Dobscha, 2009; Lambeek, 2010). These programs should assess the impact of pain and suffering on the patient's medical, physical, psychological, social, and/or vocational functioning. In general, interdisciplinary programs evaluate and treat multiple and sometimes irreversible conditions, including, but not limited to: painful musculoskeletal, neurological, and other chronic pain conditions and psychological issues; drug dependence, abuse, or addiction; high levels of stress and anxiety; failed surgery; and pre-existing or latent psychopathology. The number of professions involved on the team in a chronic pain program may vary due to the complexity of the needs of the person served. The OWCA recommends consideration of referral to an interdisciplinary program within six months post-injury in patients with delayed recovery, unless successful surgical interventions or other medical and/or psychological treatment complications intervene.

a. Chronic pain patients need to be treated as outpatients within a continuum of treatment intensity. Outpatient chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated among practices by the authorized treating physician (informal). Formal programs are able to provide a coordinated, high-intensity level of services and are recommended for most chronic pain patients who have received multiple therapies during acute management.

b. Patients with addiction problems, high-dose opioid use, or use of other drugs of abuse may require inpatient and/or outpatient chemical dependency treatment programs before or in conjunction with other interdisciplinary rehabilitation. Guidelines from the American Society of Addiction Medicine are available and may be consulted relating to the intensity of services required for different classes of patients in order to achieve successful treatment.

c. Informal interdisciplinary pain programs may be considered for patients who are currently employed, those who cannot attend all-day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach, methods, and goals. Generally, the type of outpatient program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social, and/or vocational functioning.

d. When referring a patient for formal outpatient interdisciplinary pain rehabilitation, an occupational rehabilitation program, or an opioid treatment program, the OWCA recommends the program meets the criteria of the Commission on Accreditation of Rehabilitation Facilities (CARF).

e. Inpatient pain rehabilitation programs are rarely needed but may be necessary for patients with any of the

following conditions: (a) high risk for medical instability; (b) moderate-to-severe impairment of physical/functional status; (c) moderate-to-severe pain behaviors; (d) moderate impairment of cognitive and/or emotional status; (e) dependence on medications from which he/she needs to be withdrawn; and (f) the need for 24-hour supervised nursing.

f. Whether formal or informal programs, they should be comprised of the following dimensions (CARF 2010-11).

i. **Communication.** To ensure positive functional outcomes, communication between the patient, insurer, and all professionals involved must be coordinated and consistent. Any exchange of information must be provided to all professionals, including the patient. Care decisions should be communicated to all and should include the family and/or support system.

ii. **Documentation.** Through documentation by all professionals involved and/or discussions with the patient, it should be clear that functional goals are being actively pursued and measured on a regular basis to determine their achievement or need for modification.

iii. **Treatment Modalities.** Use of modalities may be necessary early in the process to facilitate compliance with and tolerance to therapeutic exercise, physical conditioning, and increasing functional activities. Active treatments should be emphasized over passive treatments. Active and self-monitored passive treatments should encourage self-coping skills and management of pain, which can be continued independently at home or at work. Treatments that can foster a sense of dependency by the patient on the caregiver should be avoided. Treatment length should be decided based upon observed functional improvement. For a complete list of active and passive therapies, refer to Therapy—Active and Therapy—Passive. All treatment timeframes may be extended based on the patient's positive functional improvement.

iv. **Therapeutic Exercise Programs.** A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize education, independence, and the importance of an on-going exercise regimen. There is good evidence that exercise alone or part of a multi-disciplinary program results in decreased disability for workers with non-acute low back pain (Oesch, 2010). There is not sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen.

v. **Return to Work.** The authorized treating physician should continually evaluate the patient for their potential to return to work. For patients currently employed, efforts should be aimed at keeping them employed. Formal rehabilitation programs should provide assistance in creating work profiles. For more specific information regarding return to work, refer to Return to Work.

vi. **Patient Education.** Patients with pain need to re-establish a healthy balance in lifestyle. All providers should educate patients on how to overcome barriers to resuming daily activity, including pain management, decreased energy levels, financial constraints, decreased physical ability, and change in family dynamics.

vii. **Psychosocial Evaluation and Treatment.** Psychosocial evaluation should be initiated, if not previously done. Providers of care should have a thorough

understanding of the patient's personality profile, especially if dependency issues are involved. Psychosocial treatment may enhance the patient's ability to participate in pain treatment rehabilitation, manage stress, and increase their problem-solving and self-management skills.

viii. Vocational Assistance. Vocational assistance can define future employment opportunities or assist patients in obtaining future employment. Refer to Return to Work for detailed information.

g. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of the treatment program. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. Programs should have sufficient personnel to work with the individual in the following areas: behavior, functional, medical, cognitive, pain management, psychological, social and vocational.

h. Formal Interdisciplinary Rehabilitation Programs

i. Interdisciplinary Pain Rehabilitation. An Interdisciplinary Pain Rehabilitation Program provides outcome-focused, coordinated, goal-oriented interdisciplinary team services to measure and improve the functioning of persons with pain and encourage their appropriate use of health care system and services. The program can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. The program shares information about the scope of the services and the outcomes achieved with patients, authorized providers, and insurers.

(a.) The interdisciplinary team maintains consistent integration and communication to ensure that all interdisciplinary team members are aware of the plan of care for the patient, are exchanging information, and implement the plan of care. The team members make interdisciplinary team decisions with the patient and then ensure that decisions are communicated to the entire care team.

(b.) The Medical Director of the pain program should ideally be board certified in pain management; or he/she should be board certified in his/her specialty area and have completed a one-year fellowship in interdisciplinary pain medicine or palliative care recognized by a national board or have two years of experience in an interdisciplinary pain rehabilitation program. Teams that assist in the accomplishment of functional, physical, psychological, social, and vocational goals must include: a medical director, pain team physician(s), and a pain team psychologist. Professionals from other disciplines on the team may include, but are not limited to: a biofeedback therapist, an occupational therapist, a physical therapist, a registered nurse (RN), a case manager, an exercise physiologist, a psychologist, a psychiatrist, and/or a nutritionist.

(c.) Timing/Frequency/Duration

(i.) Time to Produce Effect: three to four weeks.

(ii.) Frequency: Full time programs – No less than five hours per day, five days per week; part-time programs – four hours per day, two to three days per week.

(iii.) Optimum Duration: 3 to 12 weeks at least two to three times a week. Follow-up visits weekly or every other week during the first one to two months after the initial program is completed.

(iv.) Maximum Duration: four months for full-time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, and additional follow-up based on the documented maintenance of functional gains.

ii. Occupational Rehabilitation:

(a.) This is a formal interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full work day. A full work day is case specific and is defined by the previous employment of the patient. Safe workplace practices and education of the employer and family and/or social support system regarding the person's status should be included. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return to work.

(b.) There is some evidence that an integrated care program, consisting of workplace interventions and graded activity teaching that pain need not limit activity, is effective in returning patients with chronic low back pain to work, even with minimal reported reduction of pain (Lambeek, 2010).

(c.) The occupational medicine rehabilitation interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; an occupational therapist; and a physical therapist.

(d.) As appropriate, the team may also include any of the following: chiropractor, an RN, a case manager, a psychologist, a vocational specialist, or a Certified Biofeedback Therapist.

(e.) Timing/Frequency/Duration

(i.) Time to Produce Effect: two weeks.

(ii.) Frequency: two to five visits per week, up to eight hours per day.

(iii.) Optimum Duration: two to four weeks.

(iv.) Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic and functional gains.

iii. Spinal Cord Programs:

(a) Spinal Cord Systems of Care provide coordinated, case-managed, and integrated services for people with spinal cord dysfunction, whether due to trauma or disease. The system includes an inpatient component in an organization licensed as a hospital, as well as an outpatient component. Each component endorses the active participation and choice of the persons served throughout the entire program. The Spinal Cord System of Care also provides or formally links with key components of care that address the lifelong needs of the persons served.

(b.) This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified and trained in rehabilitation, a case manager, an occupational therapist, a physical therapist, a psychologist, a rehabilitation RN and MD/DO, and a therapeutic recreation specialist. As appropriate, the team

may also include: a rehabilitation counselor, a respiratory therapist, a social worker, or a speech-language pathologist.

(c). ...

iv. Opioid/Chemical Treatment Programs: Refer to the Chronic Pain Disorder Medical Treatment Guidelines.

i. Informal Interdisciplinary Rehabilitation Program: A coordinated interdisciplinary pain rehabilitation program is one in which the authorized treating physician coordinates all aspects of care. This type of program is similar to the formal programs in that it is goal-oriented and provides interdisciplinary rehabilitation services to manage the needs of the patient in the following areas: (a) functional, (b) medical, (c) physical, (d) psychological, (e) social, and (f) vocational.

i. This program is different from a formal program in that it involves lower frequency and intensity of services/treatment. Informal rehabilitation is geared toward those patients who do not need the intensity of service offered in a formal program or who cannot attend an all-day program due to employment, daycare, language, or other barriers.

ii. Patients should be referred to professionals experienced in outpatient treatment of chronic pain. The OWCA recommends the authorized treating physician consult with physicians experienced in the treatment of chronic pain to develop the plan of care. Communication among care providers regarding clear objective goals and progress toward the goals is essential. Employers should be involved in return to work and work restrictions, and the family and/or social support system should be included in the treatment plan. Professionals from other disciplines likely to be involved include: a biofeedback therapist, an occupational therapist, a physical therapist, an RN, a psychologist, a case manager, an exercise physiologist, a psychiatrist, and/or a nutritionist.

iii. Timing/Frequency/Duration

(a). Time to Produce Effect: three to four weeks

(b). Frequency: Full time programs - no less than five hours/day, five days/week; Part time programs - four hours/day for two to three days per week.

(c). Optimum Duration: 3 to 12 weeks at least two to three times a week. With follow up visits weekly or every other week during the first one to two months after the initial program is completed.

(d). Maximum duration: four months for full time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, additional follow up based upon the documented maintenance of functional gains.

6. Medications: Use in the treatment of cervical spine injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries, from simple strains to post-surgical healing. A thorough medication history, including use of alternative and over-the-counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or nonsteroidal anti-inflammatory drugs (NSAIDs). The patient should be educated regarding the interaction of prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The medication lists below do not

provide complete information on side effects or drug interactions. Providers should seek information from other sources for details. The following medications are listed in alphabetical order:

a. Acetaminophen: An effective analgesic with anti-pyretic but not anti-inflammatory activity. Acetaminophen is generally well-tolerated, causes little or no gastrointestinal (GI) irritation, and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed three grams per 24-hour period, from all sources, including narcotic-acetaminophen combination preparations.

i. Optimum Duration: 7 to 10 days.

ii. Maximum Duration: Extended use as indicated on a case-by-case basis. Use of this substance long-term (for three days per week or greater) may be associated with rebound pain upon cessation.

b. Intravenous Steroids: The benefits of preventing neurological damage from acute spinal cord compression in an emergent situation generally outweigh the risks of pharmacologic side effects from steroids.

c. Muscle Relaxants: Appropriate for muscle spasm with pain. There is strong evidence that non-benzodiazepine muscle relaxants are more effective than placebo for providing short-term pain relief in acute low back pain ([Cochrane] van Tulder, 2003). Thus, use for patients with acute neck pain due to spasm is also accepted. When prescribing these agents, physicians must seriously consider all central nervous system (CNS) side effects including drowsiness or dizziness and the fact that benzodiazepines may be habit-forming. Carisoprodol should not be used as its active metabolite, meprobamate is commonly abused. Chronic use of benzodiazepines is not recommended due to their habit-forming potential, seizure risk following abrupt withdrawal, and documented contribution to deaths of patients on opioids due to respiratory depression. A number of muscle relaxants interact with other medications.

i. Optimum Duration: one week.

ii. Maximum Duration: two weeks (or longer if used only at night).

d. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): Useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case, with the most effective preparation being continued.

i. Patients should be closely monitored for adverse reactions. The FDA advises that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. There is good evidence that naproxen has the least risk for cardiovascular events when compared to other NSAIDs (Trelle, 2011). Administration of proton pump inhibitors, Histamine 2 Blockers or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration in those at higher risk for this adverse

event (e.g. age > 60, concurrent antiplatelet or corticosteroid therapy). They do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and it should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Patients with renal or hepatic disease may need increased dosing intervals with chronic acetaminophen use. Chronic use of NSAIDs is generally not recommended due to increased risk of cardiovascular events and GI bleeding.

ii. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent on the patient's age and general health status and should be within parameters listed for each specific medication. Complete blood count (CBC) and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

iii. Non-Selective Non-Steroidal Anti-Inflammatory Drugs:

(a) Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms, in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

(i). Optimal Duration: one week.

(ii). Maximum duration: one year. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

iv. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors:

(a) COX-2 inhibitors differ from the traditional NSAIDs in adverse side effect profiles. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less GI toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency; thus, renal function may need monitoring.

(b). COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short-term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

(i). Optimal Duration: 7 to 10 days.

(ii). Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

e. Opioids. Should be reserved for the treatment of acute severe neck pain. There are circumstances where prolonged use of opioids is justified based on diagnosis and severity of functional deficits, and in these cases, it should

be documented and justified. In mild to moderate cases of neck pain, opioid medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

i. Opioid medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the opioid prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.

(a). Optimum Duration: three to seven days.

(b). Maximum Duration: two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines, which give a detailed discussion regarding medication use in chronic pain management. Use beyond 30 days after non-traumatic injuries, or six weeks post-surgery after the original injury or post operatively is not recommended. If necessary the physician should access the Louisiana Prescription Drug Monitoring Program (PDMP) and follow recommendations in Chronic Pain Guideline. This system allows the prescribing physician to see most of the controlled substances prescribed by other physicians for an individual patient.

f. Oral Steroids: Have limited use but are accepted in cases requiring potent anti-inflammatory drug effect.-Two studies were identified for the treatment of herniated discs that did not qualify for evidence, however both used comparison placebo groups and neither showed any long-term benefit regarding pain or disability (Holve, 2008; Haimovic, 1985). There is no adequate evidence supporting oral steroids for patients with low back or neck pain with or without radiculopathy, significant side effects are possible, and they are not generally recommended (Hopwood, 1993).

g. Psychotropic/Anti-Anxiety/Hypnotic Agents: May be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Antidepressant medications, such as tricyclics and selective serotonin reuptake inhibitors (SSRIs), are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low doses, are useful for chronic neurogenic pain with difficulty sleeping but have more frequent side effects.

i. Anti-anxiety medications are best used for short-term treatment (i.e., less than six months). Accompanying sleep disorders are best treated with sedating anti-depressants prior to bedtime. Frequently, combinations of the above agents are useful. As a general rule, providers (physicians or medical psychologist) should assess the patient's prior history of substance abuse or depression prior to prescribing any of these agents.

ii. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not generally recommended. Refer to the Chronic Pain Disorder Medical Treatment Guidelines, which give a detailed discussion regarding medication use in chronic pain management.

(a). Optimum Duration: one to six months.

(b). Maximum Duration: six to twelve months, with monitoring.

h. Tramadol: May be useful in the relief of neck pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Tramadol is an atypical opioid with norepinephrine and serotonin reuptake inhibition. Tramadol is now classified as a Schedule IV controlled substance (CS) by the DEA. Although tramadol may cause impaired alertness, it is generally well-tolerated, does not cause GI ulceration, and does not exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, SSRIs, some muscle relaxants, and tricyclic antidepressants. Because it inhibits the reuptake of norepinephrine and serotonin, use with other agents that increase norepinephrine and/or serotonin (e.g. SNRIs, mirtazapine, TCAs, SSRIs) can result in serotonin syndrome. This medication has physically addictive properties, and withdrawal may follow abrupt discontinuation; thus, it is not generally recommended for those with prior opioid addiction.

i. Optimum Duration: three to seven days.

ii. Maximum Duration: two weeks. Use beyond two weeks is acceptable in appropriate cases.

7. Orthotics. Primary principles and objectives of the application of cervical orthosis include: (a) control of the position through the use of control forces; (b) application of corrective forces to abnormal curvatures; (c) aid in spinal stability when soft tissues or osteoligamentous structures cannot sufficiently perform their role as spinal stabilizers; and (d) restrict spinal segment movement after acute trauma or surgical procedure. In cases of traumatic cervical injury, the most important objective is the protection of the spinal cord and nerve root.

a. Cervical Collars:

i. Soft collars are well-tolerated by most patients but may not significantly restrict motion in any plane and may be associated with delayed recovery. There is no evidence that their use promotes recovery from isolated cervical sprain. In acute strain/sprain type injuries, use of cervical collars may prolong disability, limit early mobilization, promote psychological dependence, and limit self-activity. There is some evidence that patients encouraged to continue usual activity have less neck stiffness and headache than patients placed in cervical collars and placed on sick leave following motor vehicle crashes (Borchgrevink, 1998).

(a). There is some evidence that semi-hard collars worn during the day for three weeks and then weaned over three weeks may hasten resolution of recent onset cervical radiculopathy (Kuijper, 2009).

ii. Rigid collars, such as a Philadelphia Orthosis, are useful post-operatively or in emergency situations. These collars restrict flexion and extension motion, and to a lesser degree, lateral bending and rotation. Duration of wear post-surgery is dependent on the surgeon and degree of cervical healing, but it is generally not used beyond eight weeks.

b. ...

c. Cervicothoracic Orthosis: such as Yale and sternal occipital mandibular immobilization (SOMI) type braces, restrict flexion and extension motion to a greater degree than the Philadelphia collar and more efficiently

restrict lateral bending and rotation. Not recommended in sprain or strain type injuries.

d. - e. ...

8. Education/Informed Decision Making of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of low back pain and disability. Unfortunately, practitioners often think of education and informed decision making last, after medications, manual therapy, and surgery.

a. Informed decision making is the hallmark of a successful treatment plan. In most cases the continuum of treatment from the least invasive to the most invasive (e.g. surgery) should be discussed. The intention is to find the treatment along this continuum which most completely addresses the condition. Patients should identify their personal functional goals of treatment at the first visit. It is recommended that specific individual goals are articulated at the beginning of treatment as this is likely to lead to increased patient satisfaction above that achieved from improvement in pain or other physical function (Hazard, 2009). There is some evidence that a two day course focusing on the biopsychosocial model with an emphasis on the goals of returning to usual activities and fitness is as effective in reducing disability as six manual therapy sessions provided by physiotherapists and more limited patient education (Hay, 2005). Progress toward the individual functional goals identified should be addressed at follow up-visits and throughout treatment by other members of the health care team as well as the authorized physicians.

b. Documentation of this process should occur whenever diagnostic tests or referrals from the authorized treating physician are contemplated. The informed decision making process asks the patient to set their personal functional goals of treatment, describe their current health status and any concerns they have regarding adhering to the diagnostic or treatment plan proposed. The provider should clearly describe the following:

i. the expected functional outcomes from the proposed treatment, or expected results and plan of action if diagnostic tests are involved;

ii. any side effects and risks to the patient;

iii. required post treatment rehabilitation time and impact on work, if any;

iv. alternative therapies or diagnostic testing.

c. Before diagnostic tests or referrals for invasive treatment take place the patient should be able to clearly articulate the goals of the intervention, the general side effects and risks associated with it and their decision regarding compliance with the suggested plan. One study indicated that information provided only by video might not be sufficient education (Newcomer, 2008).

d. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with providing reassuring information to the patient and informed decision making. More in-depth education currently exists within a treatment regimen employing functional restoration, prevention, and cognitive behavioral techniques. Patient education and informed decision making should facilitate self-management of symptoms and prevention.

i. Time to produce effect: Varies with individual patient

ii. Frequency: Should occur at every visit.

9. Psychological/Psychosocial Intervention:

a. Psychosocial treatment is a well-established therapeutic and diagnostic intervention with selected use in acute pain problems and more widespread use in sub-acute and chronic pain populations. Psychosocial treatment is recommended as an important component in the total management of a patient with chronic low back pain and should be implemented as soon as the problem is identified.

b. If a diagnosis consistent with the standards of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) has been determined, the patient should be evaluated for the potential need for psychiatric medications. Use of any medication to treat a diagnosed condition may be ordered by the authorized treating physician or by the consulting psychiatrist. Visits for management of psychiatric medications are medical in nature and are not a component of psychosocial treatment. Therefore, separate visits for medication management may be necessary, depending on the patient and medications selected.

c. Psychosocial interventions include psychotherapeutic treatments for mental health conditions, as well as behavioral medicine treatments. These interventions may similarly be beneficial for patients without psychiatric conditions, but who may need to make major life changes in order to cope with pain or adjust to disability. Examples of these treatments include cognitive behavioral therapy (CBT), relaxation training, mindfulness training, and sleep hygiene training.

d. The screening or diagnostic workup should clarify and distinguish between pre-existing, aggravated, and/or purely causative psychological conditions. Therapeutic and diagnostic modalities include, but are not limited to, individual counseling and group therapy. Treatment can occur within an individualized model, a multi-disciplinary model, or a structured pain management program.

e. A licensed psychologist or a psychiatric MD/DO may perform psychosocial treatments. Other licensed mental health providers or licensed health care providers with training in CBT, or certified as CBT therapists who have experience in treating chronic pain disorders in injured workers, may also perform treatment in consultation with a licensed psychologist, or psychiatric MD/DO.

f. CBT refers to a group of psychological therapies that are sometimes referred to by more specific names, such as Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy. Variations of CBT methods can be used to treat a variety of conditions, including chronic pain, depression, anxiety, phobias, and post-traumatic stress disorder (PTSD). For patients with multiple diagnoses, more than one type of CBT might be needed. The CBT used in research studies is often "manualized CBT," meaning that the treatment follows a specific protocol in a manual (Thorn, 2004). In clinical settings, CBT may involve the use of standardized materials, but it is also commonly adapted by a psychologist or psychiatrist to the patient's unique

circumstances. If the CBT is being performed by a non-mental health professional, a manual approach would be strongly recommended. CBT must be distinguished from neuropsychological therapies used to teach compensatory strategies to brain injured patients, which are also called "cognitive therapy."

g. It should be noted that most clinical trials on CBT exclude subjects who have significant psychiatric diagnoses. Consequently, the selection of patients for CBT should include the following considerations. CBT is instructive and structured, using an educational model with homework to teach inductive rational thinking. Because of this educational model, a certain level of literacy is assumed for most CBT protocols. Patients who lack the cognitive and educational abilities required by a CBT protocol are unlikely to be successful. Further, given the highly structured nature of CBT, it is more effective when a patient's circumstances are relatively stable. For example, if a patient is about to be evicted, is actively suicidal, or is coming to sessions intoxicated, these matters will generally preempt CBT treatment for pain, and require other types of psychotherapeutic response. Conversely, literate patients whose circumstances are relatively stable, but who catastrophize or cope poorly with pain or disability are often good candidates for CBT for pain. Similarly, literate patients whose circumstances are relatively stable, but who exhibit unfounded medical phobias, are often good candidates for CBT for anxiety.

h. There is good evidence that cognitive intervention reduces low back disability in the short term and in the long term. In one of the studies the therapy consisted of six, 2-hour sessions given weekly to workers who had been sick-listed for 8 to 12 weeks. Comparison groups included those who received routine care (Storheim, 2003; Linton, 2005). There is good evidence that psychological interventions, especially CBT, are superior to no psychological intervention for chronic low back pain, and that self-regulatory interventions, such as biofeedback and relaxation training, may be equally effective (Hoffman, 2007). There is good evidence that six group therapy sessions lasting one and a half hours each focused on CBT skills improved function and alleviated pain in uncomplicated sub-acute and chronic low back pain patients (Lamb, 2010). There is some evidence that CBT provided in seven two-hour small group sessions can reduce the severity of insomnia in chronic pain patients (Currie, 2000). A Cochrane meta-analysis grouped very heterogeneous behavioral interventions and concluded that there was good evidence that CBT may reduce pain and disability but the effect size was uncertain ([Cochrane] Eccleston, 2009). In total, the evidence clearly supports CBT, and it should be offered to all chronic pain patients who do not have other serious issues, as discussed above.

i. CBT is often combined with active therapy in an interdisciplinary program, whether formal or informal. It must be coordinated with a psychologist or psychiatrist. CBT can be done in a small group or individually, and the usual number of treatments varies between 8 and 16 sessions.

j. Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or psychiatric MD/DO.

k. Psychological Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis I disorders are common in chronic pain. One study demonstrated that the majority of patients who had failed other therapy and participated in an active therapy program also suffered from major depression. However, in a program that included CBT and other psychological counseling, the success rate for return to work was similar for those with and without a DSM IV diagnosis. This study further strengthens the argument for having some psychological intervention included in all chronic pain treatment plans (Gatchel, 1994).

l. For all psychological/psychiatric interventions, an assessment and treatment plan with measurable behavioral goals, time frames, and specific interventions planned, must be provided to the treating physician prior to initiating treatment. A status report must be provided to the authorized treating physician every two weeks during initial more frequent treatment and monthly thereafter. The report should provide documentation of progress toward functional recovery and a discussion of the psychosocial issues affecting the patient's ability to participate in treatment. The report should also address pertinent issues such as pre-existing, aggravated, and/or causative issues, as well as realistic functional prognosis.

m. Cognitive Behavioral Therapy (CBT) or Similar Treatment. Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or psychiatric MD/DO.

i. Timing/Duration

(a). Time to Produce Effect: six to eight 1–2 hour session, group or individual (one hour individual or two hour group).

(b). Maximum Duration: 16 sessions.

n. Other Psychological/Psychiatric Interventions:

i. Timing/Frequency/Duration

(a). Time to Produce Effect: six to eight weeks.

(b). Frequency: one to two times weekly for the first two weeks (excluding hospitalization, if required), decreasing to one time per week for the second month. Thereafter, two to four times monthly with the exception of exacerbations, which may require increased frequency of visits. Not to include visits for medication management

(c). Optimum Duration: two to six months.

(d). Maximum Duration: six months. Not to include visits for medication management. For select patients, longer supervised psychological/psychiatric treatment may be required, especially if there are ongoing medical procedures or complications. If counseling beyond six months is indicated, the management of psychosocial risks or functional progress must be documented. Treatment plan/progress must show severity.

10. Restriction of Activities. Continuation of normal daily activities is the recommendation for chronic pain patients since immobility will negatively affect rehabilitation. Prolonged immobility results in a wide range of deleterious effects, such as a reduction in aerobic capacity and conditioning, loss of muscle strength and flexibility, increased segmental stiffness, promotion of bone demineralization, impaired disc nutrition, and the facilitation of the illness role.

a. Immobility may range from bed rest to the continued use of orthoses, such as cervical collars. While these interventions may occasionally have been ordered in the acute phase, the provider should be aware of their impact on the patient's ability to adequately comply with and successfully complete rehabilitation. With cervical pain it is generally recommended that returning to stretching and range of motion early is likely to be beneficial. Significant restriction of range of motion may render the worker unsafe for driving.

b. Patients should be educated regarding the detrimental effects of immobility versus the efficacious use of limited rest periods. Adequate rest allows the patient to comply with active treatment and benefit from the rehabilitation program. In addition, complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation and promotes disability. Modified return to work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with neck pain.

11. Return-to-Work. Return to work and/or work-related activities whenever possible is one of the major components in low back pain management and rehabilitation. There is some evidence that an integrated care program including workplace interventions and graded activity teaching that pain need not limit activity is effective in returning patients with chronic low back pain to work, even with minimal reduction of pain (Lambeek, 2010). Return to work is a subject that should be addressed by each workers' compensation provider at the first meeting with the injured employee and updated at each additional visit. A return-to-work format should be part of a company's health plan, knowing that return to work can decrease anxiety, reduce the possibility of depression, and reconnect the worker with society.

a. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset. In complex cases, experienced nurse case managers may be required to assist in return to work. Other services, including psychological evaluation and/or treatment, jobsite analysis, and vocational assistance, may be employed.

b. Two counseling sessions with an occupational physician, and work site visit if necessary, may be helpful for workers who are concerned about returning to work (Jensen, 2012b). Another study found that low back pain claimants who received information on self-care and return to work had fewer episodes of relapse than those who did not receive the advice (DuBois, 2012).

c. At least one study suggest that health status is worse for those who do not return to work than those who do. Self-employment and injury severity predict return to work. Difficulty with pain control, ADLs, and anxiety and depression were common (Kendrick, 2012).

d. The following should be considered when attempting to return an injured worker with chronic pain to work.

i. Job History Interview. The authorized treating physician should perform a job history interview at the time of the initial evaluation and before any plan of treatment is

established. Documentation should include the workers' job demands, stressors, duties of current job, and duties of job at the time of the initial injury. In addition, cognitive and social issues should be identified, and treatment of these issues should be incorporated into the plan of care.

ii. Coordination of Care. Management of the case is a significant part of return to work and may be the responsibility of the authorized treating physician, occupational health nurse, risk manager, or others. Case management is a method of communication between the primary provider, referral providers, insurer, employer, and employee. Because case management may be coordinated by a variety of professionals, the case manager should be identified in the medical record.

iii. Communication. This is essential between the patient, authorized treating physician, employer, and insurer. Employers should be contacted to verify employment status, job duties and demands, and policies regarding injured workers. In addition, the availability and duration of temporary and permanent restrictions, as well as other placement options, should be discussed and documented. All communications in the absence of the patient are required to be documented and made available to the patient.

iv. Establishment of Return-to-Work Status. Return to work for persons with chronic pain should be considered therapeutic, assuming that work is not likely to aggravate the basic problem or increase the discomfort. In most cases of chronic pain, the worker may not be currently working or even employed. The goal of return to work would be to implement a plan of care to return the worker to any level of employment with the current employer or to return him/her to any type of new employment.

v. Establishment of Activity Level Restrictions. Formal job description for the injured worker is necessary to identify physical demands at work and assist in the creation of modified duty. A jobsite evaluation may be utilized to identify applicable tasks such as pushing, pulling, lifting, reaching, grasping, pinching, sitting, standing, posture, ambulatory distance and terrain, and if applicable, environment for temperature, air flow, noise, and the number of hours that may be worked per day. Due to the lack of predictability regarding exacerbation of symptoms affecting function, an extended, occupationally focused functional capacity evaluation may be necessary to determine the patient's tolerance for job type tasks over a continued period of time. Job requirements should be reviewed for the entire eight hours or more of the working day. Between one and three days after the evaluation, there should be a follow-up evaluation by the treating therapist and/or the authorized treating physician to assess the patient's status. When prescribing the FCE, the physician must assess the probability of return to work against the potential for exacerbation of the work related condition. Work restrictions assigned by the authorized treating physician may be temporary or permanent. The case manager should continue to seek out modified work until restrictions become less cumbersome or as the worker's condition improves or deteriorates.

vi. Rehabilitation and Return to Work. As part of rehabilitation, every attempt should be made to simulate work activities so that the authorized treating physician may

promote adequate job performance. The use of ergonomic or adaptive equipment, therapeutic breaks, and interventional modalities at work may be necessary to maintain employment.

vii. Vocational Assistance. Formal vocational rehabilitation is a generally accepted intervention and can assist disabled persons to return to viable employment. Assisting patients to identify vocational goals will facilitate medical recovery and aid in the achievement of MMI by increasing motivation towards treatment and alleviating the patient's emotional distress. Chronic low back pain patients will benefit most if vocational assistance is provided during the interdisciplinary rehabilitation phase of treatment. To assess the patient's vocational capacity, a vocational assessment utilizing the information from occupational and physical therapy assessments may be utilized to identify rehabilitation program goals, as well as optimize both patient motivation and utilization of rehabilitation resources. This may be extremely helpful in decreasing the patient's fear regarding an inability to earn a living, which can add to his/her anxiety and depression.

viii. Recommendations to Employers and Employees of Small Businesses: employees of small businesses who are diagnosed with chronic pain may not be able to perform any jobs for which openings exist. Temporary employees may fill those slots while the employee functionally improves. Some small businesses hire other workers, and if the injured employee returns to the job, the supervisor/owner may have an extra employee. To avoid this, it is suggested that case managers be accessed through their payer or third-party administrator. Case managers may assist with resolution of these problems, as well as assist in finding modified job tasks, or find jobs with reduced hours, etc., depending on company philosophy and employee needs.

ix. Recommendations to Employers and Employees of Mid-sized and Large Businesses: Employers are encouraged by OWC to identify modified work within the company that may be available to injured workers with chronic pain who are returning to work with temporary or permanent restrictions. To assist with temporary or permanent placement of the injured worker, it is suggested that a program be implemented that allows the case manager to access descriptions of all jobs within the organization.

12. Therapy—Active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. A retrospective cohort study suggests that early referral to rehabilitation/physical therapy, within 14 days decreases the cost and likelihood of the need for later referrals and testing, thus decreasing overall medical costs (Fritz, 2012). Active therapies are based on the philosophy that therapeutic exercise and/or activities are beneficial for restoring flexibility, strength, endurance, function, ROM, and alleviating discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a licensed or registered occupational or physical therapist or medical provider. The supervision may include verbal, visual, and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a.i. Education and counseling should include:
(a). understanding of the strength inherent in the human spine, spinal neutral postures, and stabilization musculature (e.g., multifidus muscles),

(b). how neuroscience explains pain perception,
(c). the favorable prognosis of neck pain, 4) use of active pain coping strategies that decrease fear and catastrophizing,

(d). early resumption of normal activities while still experiencing pain, and

(e). the importance of increasing activity levels.

ii. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels (Delitto, 2012). Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The patient's baseline and progress should be measured using validated tools such as the Neck Disability Index and the Patient-Specific Functional Scale for patient with neck pain.

b.i. Therapists should notify the authorized treating physician when

(a). clinical findings suggest serious medical or psychological pathology;

(b). reported activity limitations are not consistent with the diagnosis; or

(c). symptoms are not improving subjectively or objectively after four weeks or resolving with interventions focused on normalizing body function.

ii. Various means can be used to measure the functional success of treatment however it appears that an increase of 5kg lifting or seven points on the pain disability index may be useful (Gross, 2012).

c. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" have been completed, then alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

d. The following active therapies are listed in alphabetical order:

i. Activities of Daily Living (ADLs): Well-established interventions that involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities, such as self-care, work re-integration training, homemaking, and driving.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: four to five treatments.

(ii). Frequency: three to five times per week.

(iii). Optimum Duration: four to six weeks.

(iv). Maximum Duration: six weeks.

ii. Functional Activities. These are well-established interventions that involve the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: four to five treatments.

(ii). Frequency: three to five times per week.

(iii). Optimum Duration: four to six weeks.

(iv). Maximum Duration: six weeks.

iii. Functional Electrical Stimulation. This is an accepted treatment in which the application of electrical current elicits involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy in the limbs due to a radiculopathy.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: two to six treatments.

(ii). Frequency: three times per week.

(iii). Optimum Duration: eight weeks.

(iv). Maximum Duration: eight weeks. If beneficial, provide with home unit.

iv. Neuromuscular Re-education. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception, kinesthetic sense, and coordination; and education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(a). Spinal stabilization is a generally accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(b). Timing/Frequency/Duration

(i). Time to Produce Effect: four to eight treatments.

(ii). Frequency: three times per week.

(iii). Optimum Duration: four to eight weeks.

(iv). Maximum Duration: eight weeks.

v. Therapeutic Exercise. Therapeutic exercise with or without mechanical assistance or resistance may include the following: isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength; improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception, and coordination, and increased range of motion.

(a). There is good evidence that adding exercise in combination with other interventions such as: manipulation alone, or manipulation and mobilization, or mobilization, muscle energy, and stretching, is more

effective than manipulation alone, mobilization alone, exercise alone, and other minimal intervention or education alone in reducing neck pain and disability (Bronfort, 2001; Walker, 2008; Miller, 2010; Cross, 2011). There is some evidence that mobilization, manipulation, and exercise does not provide greater long-term pain relief when compared to exercise alone (Miller, 2010).

(b). There is good evidence that manipulation alone or mobilization alone provides immediate, short-term, and intermediate term relief for acute, subacute, and chronic neck pain ([Cochrane] Gross, 2010). There is some evidence that cervico-scapular endurance exercises are beneficial for chronic cervicogenic headache ([Cochrane] Kay, 2012). There is some evidence that a program of two sessions of thoracic thrust manipulation followed by a cervical exercise program is more effective than a cervical exercise program alone (Cross, 2011).

(c). Therapeutic exercise programs should be specific to the injury and address general functional deficits as identified in the diagnosis and clinical assessment. Patients should be instructed in and receive a home exercise program that is progressed as their functional status improves. Upon discharge, the patient should be independent in the performance of the home exercise program and should have been educated in the importance of continuing such a program. Educational goals include the development of strategies to maintain or further improve function and to minimize the risk for aggravation of symptoms in the future.

(d). Timing/Frequency/Duration

(i). Time to Produce Effect: two to six treatments.

(ii). Frequency: three to five times per week.

(iii). Optimum Duration: four to eight weeks and concurrent with an active daily home exercise program.

(iv). Maximum Duration: 12 weeks of therapist oversight. Home exercise should continue indefinitely.

vi. Work Conditioning. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuro-musculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of both active and passive, in conjunction with therapeutic exercise, functional activities, general conditioning, body mechanics, and lifting techniques re-training. These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(a). Timing/Frequency/Duration

(i). Length of Visit: one to two hours per day.

(ii). Frequency: two to five visits per week.

(iii). Optimum Duration: two to four weeks.

(iv). Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

vii. Work Simulation. Work simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a functional capacity evaluation (FCE) and/or jobsite analysis.

(a). Timing/Frequency/Duration

(i). Length of Visit: two to six hours per day.

(ii). Frequency: two to five visits per week.

(iii). Optimum Duration: two to four weeks.

(iv). Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

13. Therapy—passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation, and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies, such as postural stabilization and exercise programs to help control swelling, pain, and inflammation during the active rehabilitation process. Please refer to Therapy - Active. Passive therapies may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. ...

b. The following passive therapies are listed in alphabetical order.

i. Electrical Stimulation (Unattended)—an Accepted Treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include muscle spasm, atrophy, and the need for osteogenic stimulation. A home unit should be purchased if treatment is effective, and frequent use is recommended.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: two to four treatments.

(ii). Frequency: Varies, depending upon indication, between two to three times per day to one time per week. Home unit should be purchased if treatment is effective, and frequent use is recommended.

(iii). Optimum Duration: four treatments for clinic use.

(iv). Maximum Duration: eight treatments for clinic use.

ii. Intramuscular Manual Therapy—Trigger Point Dry Needling: IMT involves using filament needles to treat "Trigger Points" within muscle. It may require multiple

advances of a filament needle to achieve a local twitch response to release muscle tension and pain. Dry needling is an effective treatment for acute and chronic pain of neuropathic origin with very few side effects. Dry needling is a technique to treat the neuro-musculoskeletal system based on pain patterns, muscular dysfunction and other orthopedic signs and symptoms.

(a). Timing/Frequency/Duration

- (i). Time to Produce Effect: Immediate
- (ii). Frequency: one to two times per week.
- (iii). Optimum Duration: six weeks.
- (iv). Maximum Duration: eight weeks.

iii. Iontophoresis. There is no proven benefit for this therapy in the neck. Not recommended due to lack of evidence in the cervical spine.

iv. Manipulation. Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease and has associated clinical significance.

(a). There is good evidence that manipulation alone or mobilization alone provides immediate, short-term, and intermediate term relief for acute, subacute, and chronic neck pain ([Cochrane] Gross, 2010). There is good quality evidence that adding exercise in combination with other interventions such as: 1) manipulation alone, or 2) manipulation and mobilization, or 3) mobilization, muscle energy, and stretching, is more effective than manipulation alone, mobilization alone, and other minimal intervention or education alone in reducing neck pain (Bronfort, 2001; Walker, 2008; Miller, 2010; Cross, 2011). There is some evidence that a three week program of twice weekly exercise with manual therapy excluding mobilization and stretching reduces neck pain and disability compared to minimal interventions (Walker, 2008). There is some evidence that mobilization, manipulation, and exercise does not provide greater long-term pain relief when compared to exercise alone (Miller, 2010).

(b). There is some evidence that thoracic thrust manipulation may improve pain and function for mechanical neck pain ([Cochrane] Gross, 2010). There is some evidence that a program of two sessions of thoracic thrust manipulation followed by a cervical exercise program is more effective than a cervical exercise program alone (Cross, 2011). There is some evidence that spinal manipulation is effective for treatment of cervicogenic headaches ([Cochrane] Bronfort, 2004). There is some evidence that exercise is equally efficacious as manipulation and can be used in combination with manipulation ([Cochrane] Bronfort, 2004). The usual course of treatment was three to six weeks and effects were still found at one year ([Cochrane] Bronfort, 2004).

(c). Manipulative treatments may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical doctors (M.D.). Some popular and useful techniques include, but are not limited to, high velocity, low amplitude (HVLA), muscle energy (ME), strain-counterstrain, a balanced ligamentous tension (BLT) and myofascial release (MFR). Under these different types of manipulation exist many subsets of techniques that can be described as: direct- a

forceful engagement of a restrictive/pathologic barrier, indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier, the patient actively assists in the treatment and the patient relaxing, allowing the practitioner to move and balance the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body, including muscles, tendons, ligaments, joints, fascia, and viscera. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment are employed.

(d). Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebralbasilar insufficiency, or carotid artery disease. Relative contraindications include stenosis, spondylosis, and disc herniation.

(e). Timing/Frequency/Duration

(i). Time to Produce Effect: four to six treatments.

(ii). Frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks. For further treatments, twice per week or less to maintain function;

(iii). Optimum Duration: eight weeks.

(iv). Maximum Duration: eight weeks. At week eight, patients should be re-evaluated.

[a]. Care beyond eight weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. In these cases, treatment may be continued at one treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co-morbidities. Such care should be re-evaluated and documented on a monthly basis.

v. Manipulation under General Anesthesia (MUA). Refers to manual manipulation of the cervical spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for its use. There have been no high quality studies to justify MUAs benefits. Given the risks of general anesthetic and conscious sedation, it is not recommended.

vi. Manipulation under Joint Anesthesia (MUJA). Refers to manipulation of the cervical spine in combination with a fluoroscopically guided injection of anesthetic with or without corticosteroid agents into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

vii. Massage—Manual or Mechanical. Massage is a generally well-accepted treatment consisting of manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of

acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range-of-motion ROM, or to increase muscle relaxation and flexibility prior to exercise. As with all passive therapies, massage must be accompanied by exercise and patient education.

- (a). Timing/Frequency/Duration
 - (i). Time to Produce Effect: Immediate.
 - (ii). Frequency: one to two times per week.
 - (iii). Optimum Duration: six weeks.
 - (iv). Maximum Duration: eight weeks.

viii. Mobilization (Joint). A mobilization treatment consisting of passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver.

(a). There is good evidence that manipulation alone or mobilization alone provides immediate, short-term, and intermediate term relief for acute, subacute, and chronic neck pain ([Cochrane] Gross, 2010). There is good quality evidence that adding exercise in combination with other interventions such as: 1) manipulation alone, or 2) manipulation and mobilization, or 3) mobilization, muscle energy, and stretching, is more effective than manipulation alone, mobilization alone, and other minimal intervention or education alone in reducing neck pain (Bronfort, 2001; Walker, 2008; Miller, 2010; Cross, 2011). There is some evidence that a three week program of twice weekly exercise with manual therapy excluding mobilization and stretching reduces neck pain and disability compared to minimal interventions (Walker, 2008). There is some evidence that mobilization, manipulation, and exercise does not provide greater long-term pain relief when compared to exercise alone (Miller, 2010).

(b). There is some evidence that thoracic thrust manipulation may improve pain and function for mechanical neck pain ([Cochrane] Gross, 2010). There is some evidence that a program of two session of thoracic thrust manipulation followed by a cervical exercise program is more effective than a cervical exercise program alone (Cross, 2011). There is some evidence that spinal manipulation is effective for treatment of cervicogenic headaches ([Cochrane] Bronfort, 2004). There is some evidence that exercise is equally efficacious as manipulation and can be used in combination with manipulation ([Cochrane] Bronfort, 2004). The usual course of treatment was three to six weeks and effects were still found at one year ([Cochrane] Bronfort, 2004).

(c). For further discussion on grade V joint mobilization, please refer to Manipulation for HVLA manipulation. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy.

(d). For Grade V mobilization, contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebrobasilar insufficiency, or carotid artery disease. Relative contraindications include stenosis, spondylosis, and disc herniation.

- (e). Timing/Frequency/Duration
 - (i). Time to Produce Effect: six to nine treatments.
 - (ii). Frequency: Up to three times per week.
 - (iii). Optimum Duration: four to six weeks.
 - (iv). Maximum Duration: six weeks.

ix. Mobilization (Soft Tissue): A generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Best practice suggests that mobilization should be accompanied by active therapy.

- (a). Timing/Frequency/Duration
 - (i). Time to Produce Effect: four to nine treatments.
 - (ii). Frequency: Up to three times per week.
 - (iii). Optimum Duration: four to six weeks.
 - (iv). Maximum Duration: six weeks

x. Short-Wave Diathermy. An accepted treatment that involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced re-absorption of hemorrhage/hematoma or edema. Best practice suggests that this modality be accompanied by active therapy.

- (a). Timing/Frequency/Duration
 - (i). Time to Produce Effect: two to four treatments.
 - (ii). Frequency: two to three times per week up to three weeks.
 - (iii). Optimum Duration: three to five weeks.
 - (iv). Maximum Duration: five weeks

xi. Superficial Heat and Cold Therapy (excluding Infrared Therapy). A generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, the need to increase pain threshold, the need to reduce muscle spasm, and the need to promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

- (a). Timing/Frequency/Duration
 - (i). Time to Produce Effect: Immediate

- (ii). Frequency: two to five times per week.
- (iii). Optimum Duration: three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months

- (iv). Maximum Duration: eight weeks.

xii. Traction—Manual. This is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation. Best practice suggests that this modality be accompanied by active therapy.

- (a). Timing/Frequency/Duration

- (i). Time to Produce Effect: one to three sessions
- (ii). Frequency: two to three times per week
- (iii). Optimum Duration: 30 days.
- (iv). Maximum Duration: one month

xiii. Traction—Mechanical. This is an accepted treatment and most commonly used for patients with radicular findings. There is some evidence that intermittent cervical traction does not add therapeutic benefit to a brief course of individualized manual therapy combined with exercise for patients with cervical radiculopathy (Young, 2009). A Cochrane review on the topic was unable to determine lack of effect or likely effect. Most studies have shown minimal or no benefit ([Cochrane] Graham, 2008). It is not generally recommended but may be useful in some cases.

- (a). It is sometimes used for patients with continuing radicular symptoms. If successful it should be shifted to home traction. Traction modalities are contraindicated in patients with other related diagnosis, such as tumor, infections, fracture, fracture/dislocation, or spinal instability. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home cervical traction unit may be purchased if therapy proves effective.

- (b). Timing/Frequency/Duration

- (i). Time to Produce Effect: one to three sessions up to 30 minutes. If response is negative after three treatments, discontinue this modality.
- (ii). Frequency: two to three times per week. A home cervical traction unit may be purchased if therapy proves effective.
- (iii). Optimum Duration: four weeks.
- (iv). Maximum Duration: four weeks.

xiv. Transcutaneous Electrical Nerve Stimulation (TENS). A generally accepted treatment that should include at least one instructional session for proper application and home use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal transcutaneous electrical nerve stimulation (TENS) unit parameters should include pulse rate, pulse width, and amplitude modulation. Consistent, measurable, functional improvement must be documented prior to the purchase of a home unit.

- (a). Timing/Frequency/Duration

- (i). Time to Produce Effect: Immediate.
- (ii). Frequency: Variable.
- (iii). Optimum Duration: three sessions.

- (iv). Maximum Duration: three sessions. Purchase or provide with home unit if effective.

- xv. Ultrasound (including Phonophoresis). There is no proven benefit for this therapy in the neck. Not recommended due to lack of evidence in the cervical spine.

14. Vocational Rehabilitation. This is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification of highest functional level, motivation, and achievement of maximum medical improvement (MMI). Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1640 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1126 (June 2014), LR 41:

§2011. Therapeutic Procedures—Operative

A. All operative interventions must be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests resulting in a reasonable likelihood of at least a measurable and meaningful functional and symptomatic improvement. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions and in most cases a specific site of nerve root compression, spinal cord compression, or spinal instability. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, psychological conditions, myofascial pain, rheumatologic, or other pain syndromes, etc.) prior to consideration of elective surgical intervention.

B. Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention (Donelson, 2012; Skytte, 2005). Patients who demonstrate centralization on directional preference testing may not need surgery when treated with directional preference neuromuscular educations (May, 2012). Refer to Therapeutic Exercise.

C. While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of cervical pain disorders, an accurate diagnosis and timely decision making for operative intervention are critical. Thorough neurologic exams should be performed periodically to assure timely treatment; to avoid de-conditioning and increased disability; and to treat emergent pathology or neurologically compromising conditions which may require early surgery.

D. Brief psychological screening tools, or more frequently full evaluations, are done to predict surgical success (Trief, 2000; Daubs, 2011). Psychological screening is indicated for all patients with continuing pain who are considering surgical interventions as indicated under the specific surgical procedure. Lower patient satisfaction after repeat surgical procedures and other treatment are related to pre-existing depression (Adogwa, 2013; Desai, 2005; Haviland, 2003).

E. In general, if the program of non-operative treatment fails, operative treatment is indicated when symptoms and findings suggest a surgically amenable problem and:

1. Improvement of the symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active therapy and manual treatment. (Mere passage of time with poorly guided treatment is not considered an active treatment program.) In cases of myelopathy and some cases of severe nerve root compression, earlier intervention is indicated or

2. Frequent recurrences of symptoms cause serious functional limitations, even if a non-operative active treatment program provides significant improvement of symptoms, and restoration of function on each recurrence; and

3. There are some clinical scenarios which necessitate surgical interventions. Surgical workup and implementation of decompression of patients with herniated nucleus pulposus and radiculopathy should occur within six to twelve weeks, at the latest, after injury within the above stated contingencies. Small herniations and most protrusions are often not pain generators, however small foraminal disc herniations are likely to compress the nerve root and may require surgical removal.

4. In order to qualify for surgery for nerve root compression, the patient should exhibit the following signs of radiculopathy before invasive procedures are considered:

- a. pain in the arms greater than in the neck which interferes with function, return to work and/or active therapy; and

- b. physical exam findings of abnormal reflexes, motor weakness or radicular sensation deficits; and

- c. findings on the MRI which indicate impingement of nerves or the spinal cord corresponding to reproducible physical exam findings.

5. Treatment of myelopathy may occur earlier. Surgical procedures should be directed toward neurological findings which correlate with MRI imaging. For the unusual patients with refractory cervical pain in whom fusion is being considered, it is strongly recommended that a decisive commitment to surgical or non-surgical interventions occur within five months following injury.

6. Re-operation is indicated only when the functional outcome following the re-operation is expected to be better, within a reasonable degree of certainty, than the outcome of other non-invasive or less invasive treatment procedures. "Functional outcomes" refer to the patient's ability to improve functional tolerances such as, standing, walking, strength, endurance, functional cervical range of motion, and/or vocational status. While timely surgical decision-making is critical to avoid de-conditioning and increased disability, a time limited trial of reconditioning should be tried prior to re-operation. Re-operation has a high rate of

complications and failure and may lead to disproportionately increased disability.

- a. For all spinal procedure reoperations, a psychosocial evaluation must be completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention.

7. Every post-operative patient should be involved in an active treatment program after clearance by the surgeon (refer to therapy-active). Interdisciplinary interventions should be strongly considered post-operatively in any patient not making functional progress within expected time frames (refer to Interdisciplinary Rehabilitation Programs).

8. Referral for surgical evaluation and treatment. Consultation should be made to an appropriate surgical specialist for surgical evaluation and treatment when operative treatment is considered.

- a. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon.

- b. Informed decision making should be documented for all invasive procedures. This must include a thorough discussion of the pros and cons of the procedure and the possible complications as well as the natural history of the identified diagnosis. Since most patients with the most common conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment.

- c. The patient and treating physician have identified functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities. The patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative treatment required and the length of partial- and full-disability expected post-operatively. The patient should have committed to the recommended post-operative treatment plan and fully completed the recommended active, manual and pre-operative treatment plans.

9. Return to work restrictions should be specific according to the recommendations in Return to Work. Most surgical patients can return to a limited level of duty between three to six weeks. Full activity is generally achieved between three months to one year, depending on the procedure, the type of duties performed, and healing of the individual. Patient should be informed of expected time off work.

F. Cervical Operative Procedures and Conditions

1. - 1.a.iv. ...

- v. Post-Operative Treatment. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Traction may be required for re-alignment and or fracture reduction

(amount to be determined by surgeon), active and/or passive therapy, pin care.

b. ...

i. Description—to provide relief of pressure on the cervical spinal cord and nerve roots, and alignment and stabilization of the spine. May involve the use of bone grafts, sometimes combined with instrumentation, to produce a rigid connection between two or more adjacent vertebrae.

ii. Complications— Instrumentation failure, such as screw loosening, plate failure, or dislodgement (more common in posterior instrumentation), incomplete decompression, bone graft donor site pain, in-hospital mortality, deep wound infection, superficial infection, graft extrusion, cerebral spinal fluid (CSF) leak, laryngeal nerve damage (anterior approach), and iatrogenic kyphosis.

iii. Surgical Indications—when a significant or progressive neurological deficit exists in the presence of spinal canal compromise or nerve root pressure.

iv. ...

(a). Choice of instrumentation is based on the patient's anatomy, the patient's pathology, and surgeon's experience and preference. Unless specifically listed in the medical treatment guidelines, the 1009 process will not decide on specific vendors, pricing, instrumentation, or products; authorization for specific product use must come from the carrier.

(b). Recombinant human bone morphogenetic protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. A retrospective analysis comparing anterior cervical fusion (ACF) and posterior cervical fusion for myelopathy or radiculopathy with and without rhBMP found that use of rhBMP increased rates of dysphagia in ACFs and increased costs for both types of fusions. The study did not report on long-term outcomes (Fineberg, 2013a). There is good evidence that rhBMP increases the likelihood of dysphagia, dysphonia and other postoperative complications when used with anterior cervical fusions (Fu, 2013) of the date of adoption the Food and Drug Administration (FDA) has not approved its use in the cervical spine. At the time of this guideline, cervical application of rhBMP-2 is not recommended. If the FDA approves its use in the cervical spine, prior authorization is required. The patient must meet all indications on the device manufacturer's list and have no contraindications.

v. Post-Operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Cervical bracing may be appropriate (usually for 6–12 weeks with fusion). Home programs with instruction in activities of daily living (ADLs), limitations in range of motion, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic

strengthening, and restoration of range of motion (ROM), is appropriate once the fusion is solid and without complication. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to therapy—active).

2. ...

a. General Recommendations: There is insufficient evidence due to weak quality of studies to determine whether recovery from cervical radiculopathy in patients without clinical signs of spinal cord compression at one year is similar for one-level discectomy and fusion; physical therapy; or rigid cervical collar use. Some non-surgical patients will recover over time (Persson, 1997). For patients with whiplash injury (Quebec Classification Grade Levels I or II), there is no evidence of any beneficial effect of operative treatment. Refer to Soft Tissue Injury Evaluation for a discussion on Quebec Classification Levels.

b. ...

c. General Indications for Surgery: Operative intervention should be considered and a consultation obtained when improvement of radicular symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of six weeks of treatment. In cases of multiple trauma or complex injuries, the procedure may be delayed due to lack of early recognition or the need to treat other conditions first. Choice of operative approach and hardware instrumentation is based on anatomy, the patient's pathology, and the surgeon's experience and preference. The 1009 process will not decide on specific vendors, pricing, instrumentation, or products; authorization for specific product use must come from the carrier.

i. Specific indications include:

(a). for patients with myelopathy expedited surgical evaluation and treatment are indicated;

(b). for patients with cervical radiculopathy: (Refer to radiculopathy as described at the beginning of this section E.4.).

(i). early intervention may be required for acute incapacitating pain or in the presence of progressive neurological deficits; persistent motor deficit; or

(ii)-(iv). ...

(v). confirmatory imaging studies, usually MRI; consistent with clinical findings; demonstrating nerve root or spinal cord compromise.

(c). For patients with persistent non-radicular cervical pain: in the absence of a radiculopathy as described at the beginning of this section in E.4, it is recommended that a decisive commitment to surgical or nonsurgical interventions be made within four to five months following injury. The effectiveness of three-level cervical fusion for non-radicular pain has not been established. In patients with non-radicular cervical pain for whom fusion is being considered, required pre-operative indications include all of the following.

(i). When the program of non-operative treatment fails, and

[a]. improvement of the symptoms has plateaued, and the residual symptoms of pain and signs of functional disability are unacceptable at the end of six months of active treatment, and/or

[b]. frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence;

[c]. mere passage of time with poorly guided treatment is not considered an active treatment program;

(ii). - (iii). ...

(iv). x-ray, MRI, or CT demonstrating spinal instability; or positive CT discography; however, Discography should never be the sole indication for surgery; and

(v). spine pathology limited to one and rarely two levels; and

(vi). psychosocial evaluation has been completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention; and

(vii). ...

ii. Surgical procedures include:

(a). Anterior Cervical Discectomy with or without Fusion

(i). Description. Procedure to relieve pressure on one or more nerve roots or the spinal cord. It may be performed with or without the use of a microscope, but generally with some form of magnification.

(ii). Complications. May include strut graft dislodgment (multi-level decompression), infection, hemorrhage, CSF leak, hematoma, catastrophic spinal cord injury causing varying degrees of paralysis, pseudarthrosis, in-hospital mortality, non-union of fusion, and donor site pain (autograft only). Anterior approach: complications increase permanent or transient dysphonia, permanent or transitory dysphagia, denervation, esophageal perforation, and airway obstruction. There is some evidence that morbid obesity increases hospital length of stay, mortality and postoperative complications of spinal fusion surgery and results in concomitant increases in cost (Kalanithi, 2012). Dysphagia is common and fusions may result in more frequent episodes of dysphagia than artificial disc replacement (McAfee, 2012; Lu, 2013; Bazaz, 2002; Kalb, 2012; Lee, 2005). There is an increased number of cardiac complications with cervical fusions in patients older than 65, who have congestive heart failure, hypertension, pulmonary circulatory abnormalities, anemia, and other cardiac comorbidities. This should be considered when determining eligibility for the procedure (Fineberg, 2013b).

(iii). Surgical Indications. Radiculopathy from ruptured disc or spondylosis, spinal instability, or patients with non-radicular neck pain meeting fusion criteria. There are no well-done studies addressing the question of whether discectomy without fusion has similar long-term

results as discectomy with fusion for specific radiculopathy cases. Anterior discectomy as an isolated procedure is rarely performed in the cervical spine but may be considered by some surgeons for patients with pure radicular symptoms from their herniated disc who have sufficiently large foramen that disc space collapse is unlikely to further compromise the nerve root ([Cochrane] Jacobs, 2011). Failure rates of non-fusion cases increase with disease at more than two levels. For any potential surgery, particularly fusions, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

(iv). Operative Treatment. Complete disc excision is usually performed. Cervical plating may be used to prevent graft dislodgment or collapse especially for multi-level disease, and to provide higher fusion rates, decreased kyphosis and increased lordosis. There does not appear to be a difference in outcome between anterior cervical discectomy and fusion performed with allograft, autograft, cage or arthroplasty for safety (Miller, 2011). There is some evidence that in cervical fusion for degenerative disease, iliac crest autograft provides greater fusion rates, but cages are a valid alternative as cages result in fewer complications from surgery ([Cochrane] Jacobs, 2011).

[a]. Recombinant Human Bone Morphogenetic Protein (rhBMP-2): is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. BMP usage in the anterior cervical spine is generally not indicated. The use of Recombinant Human Bone Morphogenetic Protein (rhBMP-2) in the cervical spine is not recommended.

(v). Post-Operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Cervical bracing may be appropriate (usually 6–12 weeks with fusion). Home programs with instruction in ADLs, limitation in range of motion, posture, and a daily walking program should be an early part of the rehabilitation process. Core strength should be emphasized. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening and restoration of functional ROM is appropriate, once fusion is solid and without complication. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered, with an emphasis on core strengthening. Manual therapy, excluding joint mobilization or manipulation may be used at the discretion of the surgeon after complete healing of the tissue and bone. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program

should include instruction in a long-term home-based exercise program. (Refer to therapy—active).

(b). Anterior Cervical Corpectomy

(i). Description. Anterior removal of a portion or the entire vertebral body to decompress the spinal canal. This usually includes removal of the adjacent discs. By definition this always involves fusion.

(ii). Complications. May include strut graft dislodgment (multi-level decompression), infection, hemorrhage, CSF leak, hematoma, catastrophic spinal cord injury causing varying degrees of paralysis, pseudarthrosis, in-hospital mortality, non-union of fusion, and donor site pain (autograft only). Anterior approach: complications increase permanent or transient dysphonia, permanent or transitory dysphagia, denervation, esophageal perforation, and airway obstruction. There is some evidence that morbid obesity increases hospital length of stay, mortality and postoperative complications of spinal fusion surgery and results in concomitant increases in cost (Kalanithi, 2012). Dysphagia is common and fusions may result in more frequent episodes of dysphagia than artificial disc replacement (McAfee, 2010; Lu, 2007; Bazaz, 2002; Kalb, 2012; Lee, 2005). There is an increased number of cardiac complications with cervical fusions in patients older than 65, who have congestive heart failure, hypertension, pulmonary circulatory abnormalities, anemia, and other cardiac comorbidities. This should be considered when determining eligibility for the procedure (Fineberg, 2013b).

(iii). Surgical Indications. Single or two-level spinal stenosis, spondylolisthesis, or severe kyphosis, with cord compression. For any potential surgery, particularly fusions, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

(iv). ...

(v). Post-Operative Therapy— An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Cervical bracing may be appropriate (usually 6–12 weeks with fusion). Home programs with instruction in ADLs, limitation in range of motion, posture, and a daily walking program should be an early part of the rehabilitation process. Core strength should be emphasized. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening and restoration of functional ROM is appropriate once fusion is solid and without complication. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered, with an emphasis on core strengthening. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Therapy – Active).

(c). Posterior Cervical Laminectomy, Foraminotomy, Discectomy with or without Fusion:

(i). Description. Surgical removal of a portion of the lamina a vertebrae in order to gain access to the spinal cord or nerve roots with or without fusion. Posterior partial laminectomy without fusion is frequently considered for lateral disc herniation.

(ii). Complications. May include perineural fibrosis, kyphosis in fractures without fusion or with failed fusion, nerve injury, post surgical instability (with foraminotomies), CSF leak, infection, in-hospital mortality, non-union of fusion, donor site pain (autograft only). There is some evidence that morbid obesity increases hospital length of stay, mortality and postoperative complications of spinal fusion surgery and results in concomitant increases in cost (Kalanithi, 2012). There is an increased number of cardiac complications with cervical fusions in patients older than 65, who have congestive heart failure, hypertension, pulmonary circulatory abnormalities, anemia, and other cardiac comorbidities. This should be considered when determining eligibility for the procedure (Fineberg, 2013b).

(iii). Surgical Indications. Neural compression. For any potential surgery, particularly fusions, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

(iv). Operative Treatment. Laminotomy, laminectomy, partial discectomy, foraminotomy and spinal cord and/or nerve root decompression with or without fusion and instrumentation. There is some evidence that in cervical fusion for degenerative disease, iliac crest autograft provides greater fusion rates, but cages are a valid alternative as cages result in fewer complications from surgery ([Cochrane] Jacobs, 2011).

(v). Post-Operative Treatment. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Cervical bracing may be appropriate (usually 6 to 12 weeks with fusion). Home programs with instruction in ADLs, limitation in range of motion, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of functional ROM is appropriate once fusion is solid and without complication. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered, with an emphasis on core strengthening. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Therapy- Active).

(d). Posterior Cervical Laminoplasty

(i). - (ii). ...

(iii). Surgical Indications. Multi-level disease: cervical spinal stenosis or spondylitic myelopathy. Not indicated in cervical kyphosis. For any potential surgery, particularly fusions, it is recommended that the injured

worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

(iv). ...

(v). **Post-Operative Therapy.** An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. May include 4 to 12 weeks of cervical bracing. Home programs with instruction in ADLs, limitation in range of motion, posture, and daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate once the cervical spine is stable and without complication. Patients should have had active therapy prior to surgery. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The goals of the therapy program should include instruction in a long-term, home-based exercise program. (Refer to Therapy- Active).

(e). **Percutaneous Discectomy:**

(i). - (iv). ...

(f). Choice of instrumentation is based on the patient's anatomy, the patient's pathology, and surgeon's experience and preference. The 1009 process will not decide on specific vendors, pricing, instrumentation, or products; authorization for specific product use must come from the carrier.

3. **Total Artificial Cervical Disc Replacement (TDR).** Involves the insertion of a prosthetic device into the cervical intervertebral space with the goal of maintaining physiologic motion at the treated cervical segment. The use of artificial discs in motion-preserving technology is based on the surgeon's preference and training. One advantage of disc replacement over fusion is the generally shorter recovery time. Two systematic reviews comparing replacement and fusion showed a tendency, but not statistically significant toward earlier return to work, and good long-term return to work for both procedures (Steinmetz, 2008; Traynelis, 2012). There is strong evidence that in patients with single level radiculopathy or myelopathy cervical artificial disc produces two year success rates at least equal to those of anterior cervical discectomy and fusion (ACDF) with allograft interbody fusion and an anterior plate (McAfee, 2012). There is some evidence that TDR requires fewer revision operations than ACDF after the first two years of treatment and that TDR slightly decreases neck pain at five years compared to ACDF. Half of the reoperations in the ACDF group were at adjacent levels (Zigler, 2013). There is good evidence that arthroplasty produces greater segmental range of motion after one to two years than fusion but its clinical significance is unknown (Boselie, 2013). Another study following disc replacement patients noted symptomatic recurrent radiculopathy at the same or adjacent segments with an annual rate of 3.1 percent. The rate of recurrence was higher for those with pre-existing

degenerative disc disease at other levels or those with significant osteopenia (Nunley, 2013).

a. **Description:** involves the insertion of a prosthetic device into an intervertebral space from which a degenerated disc has been removed, sparing only the peripheral annulus. The endplates are positioned under intraoperative fluoroscopic guidance for optimal placement in the sagittal and frontal planes. The prosthetic device is designed to distribute the mechanical load of the vertebrae in a physiologic manner and maintain ROM.

b. General selection criteria for cervical disc replacement includes symptomatic one level degenerative disc disease with radiculopathy. The patient must also meet fusion surgery criteria, and if the patient is not a candidate for fusion, a disc replacement procedure should not be considered. Additionally, the patient should be able to comply with pre-and post-surgery protocol.

c. The theoretical advantage of total disc arthroplasty is that it preserves range of motion and physiologic loading of the disc. This could be an advantage for adults who are physically active. Studies do not demonstrate a long-term advantage of measured function or pain over comparison groups undergoing fusion. The longevity of this prosthetic device has not yet been determined. Significant technical training and experience is required to perform this procedure successfully. Surgeons must be well-versed in anterior spinal techniques and should have attended appropriate training courses, or have undergone training during a fellowship. Mentoring and proctoring of procedures is highly recommended. Reasonable pre-operative evaluation may include an angiogram. The angiogram may be either with contrast or with magnetic resonance imaging.

d. **Complications:**

i. nerve and vascular injury;

ii. dural tears;

iii. mal-positioning of the prosthesis;

iv. suboptimal positioning of the prosthetic may compromise the long-term clinical result;

v. re-operation due to complications.

e. **Surgical Indications.** Patient meets one of the two sets of indications:

i. symptomatic one-level degenerative disc disease with established radiculopathy or myelopathy; and

(a). not improved after six weeks of therapy; and

(b). radiculopathy or myelopathy documented by exam and EMG; and

(c). MRI correlated with objective findings or positive at one level; or,

ii. all of the following:

(a). symptoms unrelieved after six months of active non-surgical treatment and one painful disc established with mri or discogram; and

(b). all pain generators are adequately defined and treated; and

(c). all physical medicine and manual therapy interventions are completed; and

(d). spine pathology limited to one level; and

(e). psychosocial evaluation has been completed.

Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain

psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention.

iii. Contraindications:

- (a). osteopenia, osteoporosis, or any metabolic bone disease;
- (b). significant spinal deformity/scoliosis;
- (c). symptomatic facet joint arthrosis—if imaging findings and physical findings of pain on extension and lateral bending are present, exploration of facetogenic pain should be completed prior to disc replacement for axial pain;
- (d). spinal instability;
- (e). deficient posterior elements;
- (f). infection;
- (g). previous compression or burst fracture;
- (h). multiple-level degenerative disc disease (DDD);
- (i). spondylolisthesis greater than 3 mm;
- (j). chronic steroid use or use of other medication known to interfere with bone or soft tissue healing;
- (k). allergy to device components/materials;
- (l). active malignancy;
- (m). generalized chronic pain.

iv. Post-Operative Treatment. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Section F. Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Bracing may be appropriate. A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program and neck education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated at the discretion of the surgeon. Full range of motions is limited initially. Sedentary duty may be able to begin within six weeks in uncomplicated cases. The goals of the therapy program should include instruction in a long-term home based exercise program (refer to therapy—active).

4. Percutaneous radiofrequency disc decompression: Percutaneous radiofrequency disc decompression of the cervical spine is an investigational procedure that introduces a 19-gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of a contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. The only trial was limited to a population not likely to apply to the workers' compensation population (van Middelkoop, 2013).

- a. It is not recommended.

5. Epiduroscopy and Epidural Lysis of Adhesions: Refer to Therapeutic Procedures—Non-Operative Epiduroscopy and Epidural Lysis of Adhesions.

6. - 7.a.iv.(f). ...

b. as treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as percutaneous spinal procedures gain greater acceptance. a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial x-rays over a course of three months during the latter portion of the six month period;

c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

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Chapter 20. Spine Medical Treatment Guidelines

Subchapter B. Low Back Pain

§2013. Introduction

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation (OWCA) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana Workers' Compensation Act as injured workers with chronic pain. Although the primary purpose of this document is advisory and educational, these guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1681 (June 2011), amended LR 41:

§2015. General Guideline Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer and patient through the Workers' Compensation.

2. Minimal Information for Request of Authorization. The minimum submission by a health care provider must include a current history and physical examination. As used

herein, "current" means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move

patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1682 (June 2011), amended by the

Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1155 (June 2014), LR 41:

§2016. Overview of Care

A. Low back pain is a ubiquitous condition with a lifetime prevalence of 84 percent (Cassidy, 1998) and a high recurrence rate. However, only about 15 percent of the population has severe pain with functional/disability limitations (Cassidy, 1998). Thus, the expectation is that most low back pain will respond to therapy and self-management, and not require invasive measures.

1. Low Back Pain without radicular pain or neurologic findings

a. Multiple studies confirm the importance of the first visit and the need to follow a specific process in caring for the most common low back pain patients. It is important to perform a thorough neurological evaluation to clarify a specific diagnosis. Initial treatment should be similar for all low back pain patients who do not have progressive neurologic deficits or “red flag” signs, such as cauda equina syndrome, foot drop, or evidence of epidural abscess. Back strains as well as disc herniations and spinal stenosis aggravations without progressive neurological findings can initially be treated conservatively. However, those with any radicular findings will require close follow up and repeated neurological examinations. Refer to Low Back Pain with Radicular Pain and Other Neurological Findings.

b. A careful and detailed history and neurological exam should be done at the initial visit and repeated periodically to assess for any signs of progressive or continuing weakness, or myelopathy. All care begins with patient education and presentation of treatment options for informed decision making. In the absence of “red flag” findings or objective motor deficits, there is normally no need to order imaging for these patients. Neither injections nor surgery are usually necessary until after six weeks of conservative care has failed to result in adequate functional gains. At the first visit, patients with a benign clinical exam should understand the high likelihood that their condition will improve over several weeks with return to activity and some pain management. It is essential that continual neurologic exams be completed regularly to rule out disc herniations and stenosis with accompanying neurologic findings.

c. Providers should take a thorough history on the first visit and carefully examine the patients to identify possible “yellow flags”, or conditions that predispose to more complex cases. Examples include multiple medical diagnoses, prior history of physical or emotional abuse or chronic pain, multiple unresolved musculoskeletal conditions, depression, fear-avoidant behavior, involvement in prior legal situations, drug or opioid abuse, etc. These patients may require multi-disciplinary intervention initially to avoid the development of chronic pain and the use of unnecessary diagnostic testing and prolonged treatment. Many of these issues can be identified using validated patient-completed screening tools. Patients with persistent neurologic findings will also require more progressive work-up, referral to a specialist or other treatment.

d. Health care providers are expected to discuss self-management of pain with their patients. Appropriate over-the-counter medication and ice or heat, if desired by the

patient may initially be helpful. If pain is severe, as in some cases with ruptured discs, opioids may be prescribed for a short time period (such as 3-7 days). This avoids the accumulation of unused opioids that may be available for others in the household to misuse and minimizes the likelihood of opioid dependence. Multiple repeat prescriptions for opioids should generally be avoided. If it is necessary to prescribe opioids for more than 14 days, the provider should do the following:

- i. repeat a thorough neurologic and back examination to rule out a more serious diagnosis;
- ii. check the Physician's Drug Monitoring Program (PDMP);

- iii. consider urine drug screening;

- (a). Refer to Chronic Pain Disorder Subchapter for drug screening requirements for Chronic Non-Cancer Pain Patients

- iv. follow the patient closely; and

- v. consider a short screening questionnaire for abuse risk before prescribing.

- e. All providers should emphasize return to activity with a detailed discussion describing exactly which activities should be performed and how often, as well as those activities that should be avoided. The patient should identify functional goals at the initial visit which are specific to their needs. Examples include return to work; gardening, playing softball, driving, and computer use. In the absence of instability, complete bed rest or cervical immobilization is not advisable for this group of patients. The discussion of functional goals and current recommended activities should lead to return-to-work recommendations (Australian Acute Musculoskeletal Pain Guidelines Group, 2003).

- f. Multiple studies assessing cost effectiveness and outcomes recommend the following initial interventions: education, non-opioid pain medication, and exercise or active therapy (Dagenais, 2010). Spinal manipulation and supervised physical therapy, often including directional preference treatment, may also be appropriate for some patients. The majority of patients will recover with these interventions. Return to activity is important and should include return to work at appropriate physical duty levels, possibly with reduced work hours.

- g. It is also appropriate to address smoking, as there is some evidence that patients who smoke respond less well to non-operative spine care and that quitting smoking results in greater improvement (Behrend, 2012).

- h. Given the high recovery rate for low back pain in the general population, the need for referral to physical therapy frequently depends on the presence of "yellow flags" and the need for further patient education to sustain activity participation. "Yellow flags" generally refer to psychosocial issues such as problems with supervisors, presence of depression or anxiety, social withdrawal, fear-avoidance beliefs (that activity causing pain is harmful) or belief that passive therapy alone is curative. However, one study noted decreased overall costs for low back pain if a patient is referred early to physical therapy (Fritz, 2012). Another well-done study provides some evidence that referral of patients in the first weeks of uncomplicated low back pain adds little to the otherwise favorable prognosis for acute low back pain and does incur additional short-term costs of care (Cherkin, 1998). This study did not

consider direct disability costs nor the effect on return to work. Injured workers may benefit from at least two visits with a physical therapist to reinforce return to activity and education regarding exercise and activity. Further visits may be necessary if return to restricted duty cannot be arranged; and to reinforce education regarding exercise and activity. Patients with evidence of fear avoidant behavior or other "yellow flags" are likely to require a different physical and/or psychosocial approach (Manca, 2007). Refer to the Chronic Pain Disorder Medical Treatment Guidelines.

- i. The long-term recovery is good (approximately 80 percent recovery in six weeks) for both those with radicular symptoms (usually without motor deficits) and those without radicular symptoms. Measuring the centimeter difference between the tip of the fingers and the floor in forward flexion can be a good measure of progress. In one study, this factor was directly related to results on the Roland Morris Scale at one month and one year. This measure is probably more predictive of outcome for true radicular patients. At one month, the finger to floor distance is usually reduced by 50 percent (Ekedahl, 2012).

- j. Many patients with musculoskeletal disorders also experience anxiety or depression. Using accepted screening tools periodically during visits can identify early psychological concerns. Cognitive behavioral therapy (CBT) is recommended for these patients and others who are not progressing well due to fear avoidance factors. CBT is as effective in disability populations as those without disability (Ebrahim, 2012).

- k. It is generally not appropriate to perform invasive procedures on a patient who reports only mild back pain, for example 3 points on a 10-point Visual Analog Scale (VAS) measurement. However, pain reports vary greatly among individuals with the same condition. Therefore providers should also consider any persistent compromise of physical function after compliance with recommended initial treatment. The following are examples of functional compromise: difficulty with activities of daily living, inability to participate in the recommended active therapy or lack of progress in job duty requirements.

- l. Spinal injections are unlikely to provide long-term relief for conditions such as sacroiliac (SI) joint, facet dysfunction or stenosis. Spinal injections should not be done without prior imaging to establish the diagnosis. The risks versus benefits must be carefully weighed and discussed with the patient when these interventions are considered. Both the specialist referred to and the authorized provider must thoroughly discuss and document the possible complications, the limited short-term benefits, and the need for continuing engagement in active therapy.

- m. Imaging is not recommended for at least six weeks after the initial injury unless it is necessary prior to a spinal injection or to rule out other acute diagnoses such as fracture, occult cancer, infection, lower extremity weakness, or signs of myelopathy. If a patient has persistent pain and imaging is deemed necessary, the ordering provider should document the following elements from face-to-face discussion with the patient:

- i. the specific findings that the provider is trying to rule out with imaging and how the diagnostic test will influence treatment, and

ii. the lack of importance of “degenerative disease” alone due to its frequent occurrence in asymptomatic patients

n. Providers should remember that many medical terms used to describe radiographic findings or used as diagnostic terms engender fear and concern in patients. Unexplained concerns can lead patients to believe they have a significant pathological condition when in fact, their condition is common and rarely leads to significant functional changes.

o. Surgery is usually not necessary in these patients, except in cases of symptomatic spinal instability, usually grade 2 spondylolisthesis. Refer Therapeutic Procedures – Operative for more details.

2. Low back pain with radicular and other neurological findings

a. Radicular findings from a herniated disc without progressive neurological findings, cauda equina symptoms, and/or without obvious significant continuing weakness should be treated initially according to the previous section. Seventy per cent of patients with radicular pain and non-surgical treatment are likely to have marked reduction in pain at four weeks with a 60 percent return to work. After eight months, over 90 percent would be expected to have an excellent outcome and return to work. About 20 percent will have a recurrence of symptoms (Casey, 2011). When directional preference testing is done, centralization tends to predict a favorable course with non-surgical treatment (Skytte, 2005; May, 2012).

b. Most patients should exhibit the following signs of radiculopathy before invasive procedures are considered:

i. pain in the legs greater than in the back which interferes with function, return to work and/or active therapy; and

ii. physical exam findings of abnormal reflexes, motor weakness, or radicular sensation deficits; and

iii. findings on the magnetic resonance imaging (MRI) which indicate impingement of nerves or the spinal cord corresponding to reproducible physical exam findings.

c. Patients with disc herniation and associated foot drop or cauda equina syndrome require early imaging and surgical intervention. Any patient with neurologic findings of significant weakness or significant functional impairment at six weeks should be considered for surgical referral since surgery should be performed before 12 weeks in order to assure the best outcome.

d. Spinal injections have not been shown to provide long-term beneficial effects for most back pain patients with or without radicular findings. Although complications are relatively rare, they can be catastrophic; thus, the cost benefit versus risk ratio is small. Injections can contribute to the likelihood of osteoporotic fractures later in life (Mandel, 2013). . They may be used in uncommon cases when a patient continues to have measurable functional deficits at six weeks after not making progress despite compliance with conservative treatment or for those who are incapacitated after the initial treatment for herniated discs. For further details refer to Injections – Spinal Therapeutic and/or Injections – Other (including Radio frequency).

e. Cases with objective findings causing functional impairment, such as stenosis with pain exacerbated by extension which causes limited ability to walk, may require

surgical treatment. Herniated discs with continued neurologic findings interfering with activity may also require surgery. The need for accompanying fusion is determined by evidence of lumbar instability. Patients with symptomatic disc herniation have the best chance for a good functional outcome if operated upon with three months of the onset of radicular pain. In at least one large trial the initial short-term results were superior to non-operative treatment (Weinstein, 2006). All cases requiring surgical intervention require documentation of a discussion with the patient to clarify that functional goals such as anticipated activities of daily living (ADLs) and work status align with patient expectations and goals. Refer Therapeutic Procedures – Operative for details.

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§2017. Initial Diagnostic Procedures

A. The OWCA recommends the following diagnostic procedures be considered the responsibility of the workers’ compensation carrier, at least initially, in order to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures, which should be utilized when initially diagnosing a work-related low back pain complaint, are listed below.

1. History-taking and physical examination (Hx and PE). Generally accepted, well-established and widely used procedures that establish the basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures do not complement each other, the objective clinical findings should have preference. The medical records should reasonably document the following.

a. History of Present Injury: A detailed history, taken in temporal proximity to the time of injury, should primarily guide evaluation and treatment. The history should include:

i. Mechanism of injury. This includes details of symptom onset and progression, including a detailed description and the position of the body before, during, and at the end of the incident. In the absence of a known specific incident, common positioning of the body during the work day and frequency of requirements such as lifting, pushing, and pulling should be included.

ii. Description of pain: This should include location of pain, nature of symptoms, and alleviating/exacerbating factors (e.g. sleep positions, sitting tolerance). The presence of pain at night or while at rest may be a sign of more extensive pathology. The history should include both the primary and secondary complaints (e.g., primary low back pain, secondary hip, or groin). Pain should be quantified on a Visual Analog Scale (VAS). The use of a patient-completed pain drawing, is highly recommended, especially during the first two weeks following injury, to assure that all work-related symptoms are being addressed. Screening the patient for fear-avoidance issues regarding recurrent pain may be useful initially to guide treatment (Rainville, 2011).

iii. Functional assessment: Functional ability should be assessed and documented at the beginning of

treatment. Periodic assessment should be recorded throughout the course of care to follow the trajectory of recovery. In addition to being more relevant to recovery from low back pain, functional measures are likely to be more reliable over time than pain measures. In one study of patients with lumbar spinal stenosis, functional measures such as the Oswestry Disability Index (ODI), the Swiss Spinal Stenosis Scale and the Patient Specific Functional Scale demonstrated test-retest reliability (Cleland, 2012).

iv. Patient-reported outcomes, whether of pain or function, are susceptible to a phenomenon called response shift. This refers to changes in self-evaluation which may accompany changes in health status. Patient self-reports may not coincide with objective measures of outcome, such as straight leg raising, due to reconceptualization of the impact of pain on daily function and internal recalibration of pain scales (Schwartz, 2009). Response shift has potential to obscure treatment effects in clinical trials and clinical practice, and may lead to apparent discrepancies in patient-reported outcomes following treatment interventions. While methods of measuring and accounting for response shift are not yet fully developed, understanding that the phenomenon exists can help clinicians understand what is happening when some measures of patient progress appear inconsistent with other measures of progress

v. Presence and distribution of lower extremity numbness, paresthesias, or weakness, especially if precipitated by coughing or sneezing

vi. Alteration in bowel, bladder, or sexual function; and for female patients, alteration in their menstrual cycle;

vii. Prior occupational and non-occupational injuries to the same area, including specific prior treatment, chronic or recurrent symptoms, and any functional limitations. Specific history regarding prior motor vehicle accidents may be helpful; and

viii. Ability to perform job duties and activities of daily living (ADLs) including the ability to maintain balance and walk rapidly without difficulty.

b. Past History:

i. Past medical includes neoplasm, gout, arthritis, hypertension, kidney stones, diabetes, and fractures;

ii. Review of systems includes symptoms of rheumatologic, neurologic, endocrine, neoplastic, infectious, and other systemic diseases;

iii. Type 1 or Type 2 diabetes. People with a body-mass index (BMI) greater than 30 may be at risk for the disease;

iv. Smoking history –smoking appears to be related to low back pain and may predispose patients to opioid addiction (Behrend, 2012; Cheng, 2013);

v. Medication use - prescription and non-prescription including vitamins and natural products

vi. Vocational and recreational pursuits, including military service; and

vii. History of depression, anxiety, or other psychiatric illness.

c. Physical Examination: Should include accepted tests and exam techniques applicable to the area being examined, including:

i. General inspection, including posture, stance and gait;

ii. Visual inspection;

iii. Palpation of spinous processes, facets, pelvis; and muscles noting myofascial tightness, tenderness and trigger points.

iv. Lumbar range of motion (ROM), preferably measured or quantified range of motion, quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may be indicated;

v. Examination of cervical, thoracic and lumbar spine; pelvis, and lower extremities;

vi. Nerve tension testing; Both the straight leg raising test and the slump test can be used to reproduce symptoms and are highly reproducible and correlated. Symptoms usually occur at around 50 degrees of flexion and are exacerbated by ankle dorsiflexion. The slump test is a straight leg raise performed with the patient in a seated slumped forward posture, neck flexed and arms behind the back (Walsh, 2009). A positive contralateral straight leg raising is quite specific, although less sensitively for disc herniation.

vii. Motor and sensory examination of the lower extremities with specific nerve root focus;

viii. Deep tendon reflexes with or without Babinski's;

ix. Assessment of gait, rapid walking, and balance;

x. For providers trained in the technique, repeated end range testing to establish the presence of a directional preference;

xi. A combination of multiple physical exam test results is preferred as none are independently diagnostic ([Cochrane] van der Windt, 2010);

xii. If applicable to injury, anal sphincter tone and/or perianal sensation; and

xiii. If applicable, abdominal examination, vascular examination, circumferential lower extremity measurements, or evaluation of hip or other lower extremity abnormalities;

xiv. If applicable, Waddell's signs, which include five categories of clinical signs: tenderness: superficial and non-anatomic, pain with simulation: axial loading and rotation, regional findings: sensory and motor, inconsistent with nerve root patterns distraction/inconsistency in straight leg raising findings, and over-reaction to physical examination maneuvers. Significance may be attached to positive findings in three out of five of these categories, but not to isolated findings. Waddell advocates considering Waddell's signs prior to recommending a surgical procedure. These signs should be measured routinely to identify patients requiring further assessment (i.e., biopsychosocial) prior to undergoing back surgery.

(a). It is generally agreed that Waddell's signs are associated with decreased functional performance and greater subjective pain levels, though they provide no information on the etiology of pain. Waddell signs cannot be used to predict or diagnose malingering. The presence of three out of five signs may most appropriately be viewed as a "yellow flag", or screening test, alerting clinicians to those patients who require a more comprehensive approach to their assessment and care plan. Therefore, if three out of five Waddell signs are positive in a patient with sub-acute or chronic back pain, a psychosocial evaluation should be part

of the total evaluation of the patient. Waddell's signs were researched on American and Western European populations; thus the results may not be applicable to cultures with differing concepts of pain (Waddell, 1989). Refer to Psychological/Psychosocial Evaluation.

d. Relationship to Work and Other Activity: This includes a statement of the probability that the illness or injury is medically work-related. If further information is necessary to determine work relatedness, the physician should clearly state what additional diagnostic studies or job information is required.

2. Radiographic imaging. Radiographic imaging of the lumbosacral spine is a generally accepted, well-established, and widely used diagnostic procedure when specific indications based on history and/or physical examination are present. There is some evidence that early radiographic imaging without clear indications is associated with prolonged care, although it does not change functional outcomes (Kendrick, 2001a). Therefore, it should not be routinely performed without indications. The mechanism of injury and specific indications for the radiograph should be listed on the request form to aid the radiologist and x-ray technician. Suggested indications include:

- a. History of significant trauma, especially blunt trauma or fall from a height;
- b. Age over 55 years;
- c. Suspicion of fracture, dislocation, instability, or objective evidence of neurologic deficit;
- d. Unexplained or persistent low back pain for at least six weeks or pain that is worse with rest;
- e. Localized pain, fever, constitutional symptoms, or history or exam suggestive of intravenous drug abuse, prolonged steroid use, or osteomyelitis;
- f. Suspected lesion in the lumbosacral spine due to tumor or systemic illness, such as a rheumatic/rheumatoid disorder or endocrinopathy. Suspected lesions may require special views;
- g. Flexion and extension views to evaluate instability;
- h. Past medical history suggestive of pre-existing spinal disease, osteoporosis, spinal instrumentation, or cancer; and
- i. Optionally, prior to any manipulative treatment.

3. Laboratory Testing. Laboratory tests are generally accepted, well-established, and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, underlying rheumatologic disorder, or connective tissue disorder based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. Furthermore, they may assist the provider in determining the best course of treatment for the injured worker. Tests include, but are not limited to:

- a. Complete blood count (CBC) with differential, which can detect infection, blood dyscrasias, and medication side effects;
- b. Blood-glucose level, which can be used to detect evidence of Type I or Type 2 diabetes;
- c. Erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), anti-nuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP),

which can be used to detect evidence of a rheumatologic, infectious, or connective tissue disorder;

d. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase, vitamin D levels, which can detect bone disease;

e. Urinalysis for bacteria (usually with culture and sensitivity), calcium, phosphorus, hydroxyproline, or hematuria; and

f. Liver and kidney function which may be performed for prolonged anti-inflammatory use or other medications requiring monitoring.

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§2019. Follow-Up Diagnostic Imaging and Testing Procedures

A. One diagnostic imaging or testing procedure may provide the same or distinctive information as does another procedure. Therefore, prudent choice of a single diagnostic procedure, a complement of procedures, or a sequence of procedures will optimize diagnostic accuracy; maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients.

B. All imaging and testing procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis. Clinical information obtained by history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results.

C. Clinical updates must demonstrate the patient's current status to document the need for diagnostic testing or additional treatment. A brief history, changes in clinical findings such as orthopedic and neurological tests, and measurements of function with emphasis on the current, specific physical limitations will be important when seeking approval of future care. The emphasis of the medical treatment schedule are that the determination of the need to continue treatment is based on functional improvement, and that the patient's ability (current capacity) to return to work is needed to assist in disability management.

D. Magnetic resonance imaging (MRI), myelography, or Computed Axial Tomography (CT) scanning following myelography, and other imaging procedures may provide useful information for many spinal disorders. Practitioners should be aware of the radiation doses associated with various procedures and provide appropriate warnings to patients. Unnecessary CT scans or X-rays increase the lifetime risk of cancer death (Hendricks, 2011).

E. When a diagnostic procedure, in conjunction with clinical information, can provide sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends on availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging studies. These are generally accepted, well-established, and widely used diagnostic procedures. In the absence of myelopathy, progressive neurological changes, or history of cancer, imaging usually is not appropriate until conservative therapy has been tried and has failed. Six to eight weeks of treatment is frequently an adequate period of time before an imaging procedure is in order, but the clinician should use judgment in this regard. When indicated, imaging studies can be utilized for further evaluation of the low back, based on the mechanism of injury, symptoms, and patient history.

a. When the findings of the diagnostic imaging and testing procedures are not consistent with the clinical examination, the clinical findings should have preference. There is good evidence that in the asymptomatic population, disc bulges, disc protrusions, annular tears, high intensity zone areas, and disc height loss are prevalent 40 to 60 percent of the time, depending on the condition, study, and age of the patient (Jarvik, 2001; Weishaupt, 1998). A recent study found no significant relationship between low back pain and high intensity zones of the lumbar disc, either in spatial distribution of the zone in a disc or in the number or location of discs (Wang, 2012).

b. There is some evidence that depression is a more accurate predictor of the development of low back pain than many common MRI findings, such as disc bulges, disc protrusions, modic endplate changes, disc height loss, annular tears, and facet degeneration, which are common in asymptomatic persons and are not associated with the development of low back pain (Jarvik, 2005). Therefore, the existence of these anatomic findings should not be considered relevant without physiologic and clinical correlation in an individual patient. There is some evidence that extruded discs are uncommon in asymptomatic persons and are associated with low back pain (Jarvik, 2005). Small herniations and protrusions are often not pain generators, although small foraminal disc herniations are likely to compress the nerve root and require surgical removal.

c. The studies below are listed in frequency of use, not importance:

i. Magnetic Resonance Imaging (MRI): Rarely indicated in patients with non-traumatic acute low back pain with no neuropathic signs or symptoms. It is generally the first follow-up imaging study in individuals who respond poorly to proper initial conservative care. MRI is useful in suspected nerve root compression, myelopathy, masses, infections, metastatic disease, disc herniation, annular tear, and cord contusion. MRI is contraindicated in patients with certain ferrous and other implants; however, MRI scanners compatible with pacemakers are now available.

(a.) In general, conventional full-size, high field magnet 1.5 tesla MRI provides better resolution and is preferred. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist.

ii. Specialized MRI Scans:

(a.)- (b). ...

(c.) Contrast MRI. Usually required for those with prior lumbar surgery, possible infection, possible malignancy, or tumor.

iii. Computed Axial Tomography (CT). CT scans provide excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic evaluation. It may sometimes be done as a complement to MRI scanning to better delineate bony osteophyte formation in the neural foramen. Instrument-scatter reduction software provides better resolution when metallic artifact is of concern. Unnecessary CT scanning should be avoided due to the radiation exposure contributing to cancer risk.

iv. Myelography. This is the injection of radiopaque material into the spinal subarachnoid space, with x-rays then taken to define anatomy. It may be used as a pre-surgical diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures. The use of small needles and a less toxic, water-soluble, nonionic contrast is recommended. Myelography is an invasive procedure with numerous complications, including nausea, vomiting, headache, convulsion, arachnoiditis, cerebrospinal fluid (CSF) leakage, allergic reactions, bleeding, and infection. Therefore, myelography should be considered only in the following instances:

(a.) when CT and MRI are unavailable;

(b.) when CT or MRI is contraindicated such as for morbidly obese patients or those who have undergone multiple surgical procedures; and when other tests prove non-diagnostic in the surgical candidate.

v. CT Myelogram. This test provides more detailed information about relationships between neural elements and surrounding anatomy and is appropriate in patients with multiple prior operations, tumorous conditions, or those that cannot have MRIs due to implants, etc.

vi. Single Photon Emission Computerized Tomography (SPECT). A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans & CT Scans in looking for facet joint pathology.

vii. Lineal Tomography. This is infrequently used, yet may be helpful in the evaluation of bone surfaces, bony fusion, or pseudarthrosis.

viii. Bone Scan (Radioisotope Bone Scanning). Bone scanning is generally accepted, well-established, and widely used. It is more sensitive but less specific than MRI. ^{99m}Tc Technetium diphosphonate uptake reflects osteoblastic activity and may be useful in diagnosing metastatic/primary bone tumors, occult or stress fractures, osteomyelitis, infection, and other inflammatory lesions, but it cannot distinguish between these conditions.

ix. Other Radioisotope Scanning. Indium and gallium scans are generally accepted, well-established, widely used procedures, and often used to diagnose lesions seen on other diagnostic imaging studies. ⁶⁷Ga Gallium citrate scans are used to localize tumors, infections, and abscesses. ¹¹¹In Indium-labeled leukocyte scanning is utilized for localizing infection or inflammation and is usually not used for the lumbar spine.

x. Dynamic [Digital] Fluoroscopy. Dynamic [Digital] Fluoroscopy of the lumbar spine measures the motion of intervertebral segments using a videofluoroscopy unit to capture images as the subject performs lumbar flexion and extension, storing the anatomic motion of the spine in a computer. Currently, it is not recommended for use in the diagnosis of lumbar instability because there is limited information on normal segmental motion for the age groups commonly presenting with low back pain, and diagnostic criteria for specific spinal conditions are not yet defined. No studies have yet demonstrated predictive value in terms of standard operative and non-operative therapeutic outcomes.

xi. Indications for Repeat Imaging or Testing:

(a). Progressive neurological change; or

(b). Onset of myelopathy; or

(c). Approved surgical intervention where most recent scan is more than 12 months prior.

2. Other tests. The following diagnostic procedures in this subsection are listed in alphabetical order, not by importance:

a. Electro-diagnostic Testing:

i. Electromyography (EMG) and Nerve Conduction Studies (NCS): These are generally accepted, well-established, and widely used diagnostic procedures. EMG and NCS, when performed and interpreted by a trained physician / electrophysiologist, may be useful for patients with suspected neural involvement whose symptoms are persistent or unresponsive to initial conservative treatments. They are used to differentiate peripheral neural deficits from radicular and spinal cord neural deficits and to rule out concomitant myopathy. However, F-Wave latencies are not diagnostic for radiculopathy. H-reflex Studies are of value regarding S-1 radiculopathy.

(a). In general, EMG and NCS are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electro-diagnostic studies may provide useful, correlative neuropathophysiological information that would be otherwise unobtainable from the radiologic studies discussed above and can assist in treatment decisions, such as the need for surgery.

ii. Portable Automated Electro-diagnostic Device (also known as Surface EMG): This is not a substitute for conventional diagnostic testing in clinical decision-making, and therefore, is not recommended.

iii. Somatosensory Evoked Potential (SSEP): Not recommended to identify radiculopathy. It may be used to evaluate myelopathy and other rare neurological disorders, such as neurogenic bladder and sexual dysfunction.

iv. Current Perception Threshold (CPT) Evaluation: May be useful as a screening tool, but its diagnostic efficacy in the evaluation of industrial low back pain has not been determined. Therefore, CPT is not recommended as a diagnostic tool.

v. Large Array Surface Electromyography: Measures low back muscle activity using a fixed array of 63 electrodes arranged in nine rows and seven columns between the seventh thoracic spinous process and the iliac crest. The array simultaneously collects myoelectric data from multifidus, iliocostalis, quadratus lumborum, and other lumbar muscles, which is analyzed for patterns of activity in

these muscle groups. It is used in researching physiologic changes and adaptations to back pain, but is not recommended as a diagnostic procedure for individuals with back pain due to a lack of interpretive standards.

vi. Surface EMG in combination with Range of Motion and/or Functional Capacity Evaluation, and/or a Comprehensive Muscular Activity Profile: These tests are designed to detect differences between persons with and without low back pain, measuring signals in lumbar flexion, which show that painful paraspinal muscles fail to relax fully. It may show aspects of the pathophysiology of muscle activity, which advance the scientific understanding of low back pain. Some versions of this test also purport to determine the significance of disc pathology and the age of an injury. It has not been evaluated in a setting with a spectrum of patients commonly seen in clinical practice, and tested against a diagnostic reference standard.

(a.) The comprehensive muscular activity profile version of this test has been shown to correctly identify healthy subjects who have been instructed to perform at less than full effort on lifting tests from those who are performing at full effort (Gatchel, 2009a). This aspect has not been tested within a group of low back patients. It may provide some information as to possible neurologic or musculoskeletal diagnoses, but it cannot be used alone to definitively diagnose a medical condition. It is not recommended as a diagnostic tool and cannot distinguish malingering from sub-maximal effort for other reasons, such as fear/avoidance behavior. Therefore, these tests are not suitable as a diagnostic test for low back pain, and their use for this purpose is not recommended.

b. Injections – Diagnostic:

i. ...

ii. Indications. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. All spinal injections should be preceded by either an MRI or a CT scan. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms. Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be primary pain generators. Patients should not receive all of the available or related diagnostic blocks listed merely in an attempt to identify 100 percent of the pain generators.

iii. – vii. (b)(ii). ...

(c). Zygapophyseal (Facet) Blocks. Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to Injections- Spinal Therapeutic)

(c)(i). - (d)(ii). ...

(e). Psychosocial Evaluation: Generally accepted and well-established diagnostic procedures with selective use in the acute low back pain populations and more widespread use in sub-acute and chronic low back pain populations.

i. These diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for pre-operative evaluation, as well as a possible predictive value for post-operative response. Psychological testing should provide differentiation between pre-existing depression versus injury-caused depression, as well as post-traumatic stress disorder. There is some evidence that depression is a more accurate predictor of the development of low back pain than many common MRI findings, such as disc bulges, disc protrusions, Modic endplate changes, disc height loss, annular tears, and facet degeneration, which are common in asymptomatic persons and are not associated with the development of low back pain (Jarvik, 2005).

ii. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- (a.) Employment history;
- (b.) Interpersonal relationships, both social and work;
- (c.) Leisure activities;
- (d.) Current perception of the medical system;
- (e.) Results of current treatment;
- (f.) Perceived locus of control; and
- (g.) Childhood history, including history of childhood psychological trauma, abuse and family history of disability.

iii. Psychological/ psychosocial evaluations consist of two components, clinical interview and psychological testing. This information should provide clinicians with a better understanding of the patient. Thus allowing more effective rehabilitation. The evaluation will determine the need for further psychosocial interventions, and in those cases, a Diagnostic Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with Psychiatric MD/DO credentials or a licensed Psychologist should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided. When issues of chronic pain are identified, the evaluation should be more extensive and follow testing procedures as outlined in the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

(a). Frequency: One time visit for interview evaluation. If psychometric testing is indicated as a portion

of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

iv. Unless objective medical findings explain symptom persistence, any patient who has not returned to work by six months will be required to undergo a full Psychosocial Evaluation by a Psychiatrist or licensed Psychologist. (See Chronic Pain Disorder subchapter, Section 2109.2 for details)

d. Provocation Discography

i. - ii. (b). ...

(c). There is good evidence that a positive discogram does not predict positive results from a fusion with the same success rate as documented spondylolisthesis (27 percent success rate compared to 72 percent success rate) (Carragee, 2006b). A similar prospective study found that a painful disc (that is, a positive discogram) is a poor independent predictor of low back pain in initially asymptomatic subjects. Psychometric profiles, work loss, medication usage were strongly predictive of subsequent low back pain. An annular tear of high intensity zone on MRI was weakly associated (Carragee, 2004). There is some evidence that discography with a small-bore needle increases the risk of later disc herniation at the injected level, and this risk should be taken into account when deciding on a referral for discography (Carragee, 2009a).

(d). Discography is not useful in previously operated discs, but may have a limited place in the work-up of pseudarthrosis. Discography may prove useful in evaluating the number of lumbar spine levels that might require fusion. CT-Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

iii. - iii.(d). ...

iv. Complications: Include, but are not limited to, discitis, nerve damage, chemical meningitis, pain exacerbation, and anaphylaxis therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

v. Contraindications: Include active infection of any type or continuing antibiotic treatment for infection; and/or bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or presence of clinical myelopathy; and/or effacement of the cord, thecal sac or circumferential absence of epidural fat; and known allergic reactions.

vi. - vii.(b). ...

(c). Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

- (i). Grade 0 = Normal Nucleus.
- (ii). Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.
- (iii). Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.
- (iv). Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.
- (v). Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.

(vi). Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

(d). Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society (ISIS) Guidelines or American Society of Interventional Pain Physicians (ASIPP) Guidelines. The report must include the level of concordance for back pain and leg pain separately using a 10-point VAS, or similar quantitative assessment. It should be noted that change in the VAS scale before and after provocation is more important than the number reported.

(e) The definition of a positive discogram is noted below. Two control discs are no longer routinely recommended due to the possibility that a disc injection alone may cause later pathology. A Positive Discogram:

(i). Stimulation of the target disc reproduces concordant pain; and

(ii). The pain is registered as at least 7 on a 10-point VAS; and has increased significantly from the baseline value; and

(iii). The pain is reproduced at a pressure of less than 50 psi above opening pressure; and

(iv). Stimulation of at least one adjacent disc does not produce pain at all.

(v). If the patient does not qualify using the criteria above, then the discogram should be considered negative. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

viii. Time Parameters for provocation discography are as follows:

(a). Frequency: One time only.

(b). Maximum Duration: Repeat Discography is rarely indicated.

e. Thermography: An accepted and established procedure, but it has no use as a diagnostic test for low back pain. It may be used to diagnose complex regional pain disorders. Refer to the OWCA's Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. Special tests. These are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and physical work demand classifications and tolerance. The procedures in this subsection are listed in alphabetical order, not by importance.

a. Computer-Enhanced Evaluations. These may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement; range of motion (ROM); endurance; or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment, and demonstrated motivation. These evaluations should not be used alone to determine return-to-work restrictions.

i. Frequency: One time for evaluation, one for mid-treatment assessment, and one at final evaluation.

b. - b.ii.(a). ...

c. Jobsite Evaluation: A comprehensive analysis of the physical, mental, and sensory components of a specific job. These components may include, but are not limited to: postural tolerance (static and dynamic); aerobic

requirements; ROM; torque/force; lifting/carrying; cognitive demands; social interactions; visual perception; sensation; coordination; environmental factors of a job; repetitiveness; and essential job functions.

i. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work.

ii. - ii.(e). ...

iii. Frequency: One time with one to two additional visits as needed for follow-up per jobsite.

d. Vocational Assessment: If the injury is such that the practitioner can easily determine that the worker will be unable to return to his/her previous occupation, then vocational assessment at that time may aid in the overall medical management and rehabilitation of the patient. The physician may decide that the patient is unable to return to the previous occupation prior to declaration of maximum medical improvement (MMI).

i. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. The physician should have identified the expected permanent limitation(s) prior to the assessment. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

ii. Frequency: One time with additional visits as needed for follow-up.

e. Work Tolerance Screening: A determination of an individual's tolerance for performing a specific job as based on a job activity or task and is generally preferable to a full FCE. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular fitness, physical fitness, and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential.

i. Frequency: One time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1658 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1137 (June 2014).

§2021. Therapeutic Procedures—Non-Operative

A. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these four important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to Return to Work for detailed information.

C. ...

1. Reassessment of the patient's status in terms of functional improvement should be documented after each treatment. If patients are not responding within the recommended time periods, alternative treatment

interventions, further diagnostic studies or consultations should be pursued. Continued treatment should be monitored using objective measures such as:

- a. Return-to-work or maintaining work status;
- b. Fewer restrictions at work or performing activities of daily living;
- c. Decrease in usage of medications;
- d. Measurable functional gains, such as increased range of motion or documented increase in strength

D. Third, providers should provide and document patient education. Before diagnostic tests or referrals for invasive treatment take place, the patient should be able to clearly articulate the goals of the intervention, the general side effects and associated risks, and the patient's agreement with the expected treatment plan.

E. Last, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. Home therapy is an important component of therapy and may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone.

G. The following procedures are listed in alphabetical order.

1. Acupuncture

a. When acupuncture has been studied in randomized clinical trials, it is often compared with sham acupuncture and/or no acupuncture (usual care). The differences between true acupuncture and usual care have been moderate, but clinically important. These differences can be partitioned into two components: non-specific effects and specific effects. Non-specific effects include patient beliefs and expectations, attention from the acupuncturist, administration of acupuncture in a relaxing setting, and other components of what is often called the placebo effect. Specific effects refer to any additional effects which occur in the same setting of expectations and attention, but they are attributable to the penetration of the skin in the specific, classic acupuncture points on the surface of the body by the needles themselves.

b. There is good evidence that acupuncture, true or sham, is superior to usual care for the reduction of disability and pain in patients with chronic nonspecific low back pain, and that true and sham acupuncture are likely to be equally effective (Cherkin, 2009). A sham procedure is a non-therapeutic procedure that appears similar to the patient as the purported therapeutic procedure being tested. In most controlled studies, sham and classic acupuncture have produced similar effects. However, the sham controlled studies have shown consistent advantages of both true and sham acupuncture over no acupuncture when the studies have included a third comparison group that was randomized to usual medical care. Having this third comparison group has been advantageous in the interpretation of the non-specific effects of acupuncture, since the third comparison group controls for some influences on study outcome. These influences include more frequent contact with providers, the natural history of the condition, regression to the mean, the effect of being observed in a clinical trial, and, if the follow-up observations are done consistently in all three treatment

groups, for biased reporting of outcomes. Controlling for these factors enables researchers to more closely estimate the contextual and personal interactive effects of acupuncture as it is generally practiced.

c. Because the sham acupuncture interventions in the clinical trials are generally done by trained acupuncturists, and not by totally untrained personnel, the sham acupuncture interventions may include some of the effects of true acupuncture (Dincer, 2003), much as a partial agonist of a drug may produce some of the effects of the actual drug. For example, a sham procedure involving toothpicks rather than acupuncture needles may stimulate cutaneous afferents in spite of not penetrating the skin, much as a neurological sensory examination may test nociceptor function without skin penetration. To the extent that afferent stimulation is part of the mechanism of action of acupuncture, interpreting the sham results as purely a control group would lead to an underestimation of the analgesic effects of acupuncture. Thus we consider in our analysis that "sham" or non-classic acupuncture may have a positive clinical effect when compared to usual care.

d. Clinical trials of acupuncture typically enroll participants who are interested in acupuncture, and who may respond to some of the non-specific aspects of the intervention more than would be expected of patients who have no interest in or desire for acupuncture. The non-specific effects of acupuncture may not be produced in patients who have no wish to be referred for it.

e. There is good evidence there is a likely, small clinical benefit of acupuncture for acute low back pain and it may be considered an alternative for some patients (Lee, 2013). There is good evidence that both acupuncture and sham acupuncture are superior to usual care without acupuncture for moderate short-term and mild long-term alleviation of low back pain, neck pain, and the pain of joint osteoarthritis (Brinkhaus, 2006; Ernst, 2011; Haake, 2007). Another study provides good evidence that true acupuncture at traditional medians is marginally better than sham acupuncture with blunt needles in reducing pain, but effects on disability are unclear (Cho, 2013). In these studies 5–15 treatments were provided. Comparisons of acupuncture and sham acupuncture have been inconsistent, and the advantage of true over sham acupuncture has been small in relation to the advantage of sham over no acupuncture.

f. Acupuncture is recommended for subacute or chronic pain patients who are trying to increase function and/or decrease medication usage and have an expressed interest in this modality. It is also recommended for subacute or acute low back pain for patients who cannot tolerate nonsteroidal anti-inflammatory drugs (NSAIDs) or other medications. Acupuncture is not the same procedure as dry needling for coding purposes; however, some acupuncturists may use acupuncture treatment for myofascial trigger points. Dry needling is performed specifically on myofascial trigger points. Refer to Dry Needling Treatment.

g. Credentialed practitioners with experience in evaluation and treatment of chronic pain patients must perform acupuncture evaluations. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly

used as an alternative or in addition to traditional Western pharmaceuticals. It may be used when pain medication is reduced or not tolerated; as an adjunct to physical rehabilitation and surgical intervention; and/or as part of multidisciplinary treatment to hasten the return of functional activity. Acupuncture must be performed by practitioners with the appropriate credentials in accordance with state and other applicable regulations. Therefore, if not otherwise within their professional scope of practice and licensure, those performing acupuncture must have the appropriate credentials, such as L.A.c., R.A.c, or Dipl. Ac.

h. Acupuncture: is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture has a variety of possible physiologic actions, but their relevance to the clinical response is speculative. For example, one crossover trial measured increasing palmar blood flow and increased nitric oxide synthase activity in arms which had had acupuncture, but this observation may have no bearing on actual analgesic effects (Tsuchiya, 2007).

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

i. Acupuncture with Electrical Stimulation: The use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

j. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Therapeutic Exercise, Massage – Manual or Mechanical, and Superficial Heat and Cold Therapy (excluding Infrared Therapy) for a description of these adjunctive acupuncture modalities and time frames.

k. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

- i. Time to Produce Effect: three to six treatments.
- ii. Frequency: one to three times per week.
- iii. Optimum Duration: one to two months.
- iv. Maximum Duration: 15 treatments.

l. Any of the above acupuncture treatments may extend longer if objective functional gains can be documented and when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 15 treatments must be documented with respect to need and the ability to facilitate positive symptomatic and

functional gains. Such care should be re-evaluated and documented with each series of treatments. All treatments should be accompanied by active therapy.

2. Biofeedback. A form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Stress-related psycho-physiological reactions may arise as a reaction to organic pain and in some cases may cause pain. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorily, or tactilely, with coaching by a biofeedback specialist. There is good evidence that biofeedback or relaxation therapy is equal in effect to cognitive behavioral therapy for chronic low back pain (Hoffman, 2007).

a. Indications for biofeedback include cases of musculoskeletal injury, in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of pain, anxiety, panic, anger or emotional distress, opioid withdrawal, insomnia/sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized for relaxation training. Mental health professionals may also utilize it as a component of psychotherapy, where biofeedback and other behavioral techniques are integrated with psychotherapeutic interventions. Biofeedback is often used in conjunction with physical therapy or medical treatment.

b. Recognized types of biofeedback include the following:

i. Electromyogram (EMG): Used for self-management of pain and stress reactions involving muscle tension.

ii. Skin Temperature: Used for self-management of pain and stress reactions, especially vascular headaches.

iii. Respiration Feedback (RFB): Used for self-management of pain and stress reactions via breathing control.

iv. Respiratory Sinus Arrhythmia (RSA): Used for self-management of pain and stress reactions via synchronous control of heart rate and respiration. Respiratory sinus arrhythmia is a benign phenomenon that consists of a small rise in heart rate during inhalation, and a corresponding decrease during exhalation. This phenomenon has been observed in meditators and athletes, and is thought to be a psycho-physiological indicator of health.

v. Heart Rate Variability (HRV): Used for self-management of stress via managing cardiac reactivity.

vi. Electrodermal Response (EDR): Used for self-management of stress involving palmar sweating or galvanic skin response.

vii. Electroencephalograph (EEG, QEEG): Used for self-management of various psychological states by controlling brainwaves.

c. The goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training should be motivated to learn and practice biofeedback and

self-regulation techniques. In the course of biofeedback treatment, patient stressors are discussed and self-management strategies are devised. If the patient has not been previously evaluated, a psychological evaluation should be performed prior to beginning biofeedback treatment for chronic pain. The psychological evaluation may reveal cognitive difficulties, belief system conflicts, somatic delusions, secondary gain issues, hypochondriasis, and possible biases in patient self-reports, which can affect biofeedback. Home practice of skills is often helpful for mastery and may be facilitated by the use of home training tapes.

d. Psychologists or psychiatrists who provide psycho-physiological therapy, which integrates biofeedback with psychotherapy, should be either Biofeedback Certification International Alliance (BCIA) certified or practicing within the scope of their training. All non-licensed health care providers of biofeedback for chronic pain patients must be BCIA certified and shall have their biofeedback treatment plan approved by the authorized treating psychologist or psychiatrist. Biofeedback treatment must be done in conjunction with the patient's psychosocial intervention. Biofeedback may also be provided by health care providers who follow a set treatment and educational protocol. Such treatment may utilize standardized material or relaxation tapes.

e. Timing/Frequency/Duration

- i. Time to Produce Effect: three to four sessions.
- ii. Frequency: one to two times per week.
- iii. Optimum Duration: six to eight sessions.
- iv. Maximum Duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic and functional gains.

3. Injections—Spinal Therapeutic

a. General Discussion and Indications

i. Description: Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. Therapeutic injections should only be used after diagnostic injections and/or imaging studies have established. Injections are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to.

ii. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to Therapy-Active). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active range of motion (ROM), strength, and stability. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings

iii. Special Requirements for Spinal Therapeutic Injections - For all injections (excluding trigger point), multi-planar fluoroscopic guidance during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, neurology, surgery, or physiatry. The practitioner should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. They must also be knowledgeable in radiation safety.

iv. Complications: General complications of spinal injections may include transient neurapraxia, local pain, nerve injury, infection, headache, urinary retention, and vasovagal effects, epidural hematoma, permanent neurologic damage, dural perforation, cerebrospinal fluid (CSF) leakage, and/or spinal meningeal abscess may also occur. Permanent paresis, anaphylaxis, arachnoiditis, and death have been rarely reported with the use of epidural steroids. With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary-adrenal axis lasting between one and three months.

v. Contraindications: Absolute contraindications to therapeutic injections include: bacterial infection – systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy.

vi. Relative contraindications to therapeutic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus for steroid injections, and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to American Society of Regional Anesthesia for anticoagulation guidelines.

b. Lumbar Epidural Steroid Injection (ESI)

i. - iii.(c). ...

iv. Timing/Frequency/Duration

(a). Time to produce effect: Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

(b). Frequency: Interlaminar (midline) or caudal techniques should be limited to one level per session. Transforaminal epidural injections should be limited to two levels per session. Whether injections are repeated depends upon the patient's response to the previous injection. Subsequent injections may occur after one to two weeks if patient response has been favorable. Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. Injections should provide a positive patient response: Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior,

and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

(c). Optimum duration: Usually one to three injection(s) over a period of six months depending upon each patient's response and functional gain.

(d). Maximum duration: Two sessions (consisting of up to three injections each) may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

c. Intradiscal Steroid Therapy

i. Intradiscal Steroid Therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography.

ii. There is good evidence that it is not effective in the treatment of suspected discogenic back pain and its use is not recommended.

d. Sacroiliac Joint Injection -

i. Description. A generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under fluoroscopic guidance. May include the use of corticosteroids. Long-term therapeutic effect has not yet been established.

ii. Indications. primarily diagnostic to rule out sacroiliac joint dysfunction vs. other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick's test) on post-injection physical exam.

iii. Timing/Frequency/Duration

(a). Time to produce effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(b). Frequency and optimum duration: Two to three injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection. Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

(c). Maximum duration: Four injections per year.

(d). These Injections may be repeated if they result in increased documented functional benefit for at least six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

e. Transforaminal Injection with Etanercept

i. Description. Transforaminal injection with a tumor necrosis factor alpha inhibitor is thought to decrease the inflammatory agents which may be associated with the pathophysiology of lumbar radicular pain from a herniated disc.

ii. It is not recommended due to the results of a study which showed no advantage over steroids or saline injections (Cohen, 2012).

f. Zygapophyseal (Facet) Injection

i. Description. a generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. Medial branch nerve blocks are diagnostic only. There is conflicting evidence to support a long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

ii. Indications. Patients with pain 1) suspected to be facet in origin based on exam findings and 2) affecting activity; OR patients who have refused a rhizotomy; OR patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a radiofrequency neurotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

iii. Timing/Frequency/Duration

(a). Time to produce effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

(b). Frequency: One injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection. Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

(c). Optimum duration: Two to three injections for each applicable joint per year. Not to exceed two joint levels.

(d). Maximum Duration: Two per level per year. Prior authorization must be obtained for injections beyond two levels.

(e). Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

4. Injections. Other including Radio Frequency. The following are in alphabetical order:

a. Botulinum Toxin Injections

i. Description. Used to temporarily weaken or paralyze muscles. These injections may reduce muscle pain in conditions associated with spasticity or dystonia. Neutralizing antibodies develop in at least four percent of patients treated with botulinum toxin type A, rendering it ineffective. Several antigenic types of botulinum toxin have been described. Botulinum toxin type B, first approved by the Food and Drug Administration (FDA) in 2001, is similar pharmacologically to botulinum toxin type A. It appears to be effective in patients who have become resistant to the type A toxin. The immune responses to botulinum toxins type A and B are not cross-reactive, allowing type B toxin to

be used when type A action is blocked by antibody. Experimental work with healthy human volunteers suggests that muscle paralysis from type B toxin is not as complete or as long lasting as that resulting from type A. The duration of treatment effect of botulinum toxin type B for cervical dystonia has been estimated to be 12 to 16 weeks. Electromyography (EMG) needle guidance may permit more precise delivery of botulinum toxin to the target area.

ii. There is a lack of adequate evidence supporting the use of these injections to lumbar musculature for the relief of isolated low back pain ([Cochrane] Waseem, 2011). There is insufficient evidence to support its use for longer-term pain relief of other myofascial trigger points and it is likely to cause muscle weakness or atrophy if used repeatedly (Ferrante, 2005; Gobel, 2006; Porta, 2000). Examples of such consequences include subacromial impingement, as the stabilizers of the shoulder are weakened by repeated injections of trigger points in the upper trapezii. Therefore, it is not recommended for use for low back pain or other myofascial trigger points (Abbott, 2007).

iii. They may be used for chronic piriformis syndrome. There is some evidence to support injections for electromyographically proven piriformis syndrome (Fishman, 2002a). Prior to consideration of botulinum toxin injection for piriformis syndrome, patients should have had marked (80 percent or better) but temporary improvement, verified with demonstrated improvement in functional activities, from three separate trigger point injections. To be a candidate for botulinum toxin injection for piriformis syndrome, patients should have had symptoms return to baseline or near baseline despite an appropriate stretching program after trigger point injections. Botulinum toxin injections of the piriformis muscle should be performed by a physician experienced in this procedure and utilize either ultrasound, fluoroscopy, or EMG needle guidance. Botulinum toxin should be followed by limb strengthening and reactivation.

iv. Indications. Piriformis syndrome established by 3 trigger point injections and unrelieved by other therapy.

b. Epiduroscopy and Epidural Lysis of Adhesions: A controversial and investigational treatment of low back pain. It involves the introduction of a fiberoptic endoscope into the epidural space via the sacral hiatus. With cephalad advancement of the endoscope under direct visualization, the epidural space is irrigated with saline. Adhesiolysis may be done mechanically with a fiberoptic endoscope. The saline irrigation is performed with or without epiduroscopy and is intended to distend the epidural space in order to obtain an adequate visual field. It is designed to produce lysis of adhesions, which are conjectured to produce symptoms due to traction on painful nerve roots. Saline irrigation is associated with risks of elevated pressures which may impede blood flow and venous return, possibly causing ischemia of the cauda equina and retinal hemorrhage.

i. Other complications associated with instrumented lysis include catheter shearing, need for catheter surgical removal, infection (including meningitis), hematoma, and possible severe hemodynamic instability during application. Although epidural adhesions have been postulated to cause chronic low back pain, studies have failed to find a significant correlation between the level of fibrosis and pain or difficulty functioning. Studies of

epidural lysis demonstrate no transient pain relief from the procedure (Dashfield, 2005). Given the low likelihood of a positive response, the additional costs and time requirement, and the possible complications from the procedure, epiduroscopy, or mechanical lysis, is not recommended.

ii. Epiduroscopy-directed steroid injections are also not recommended because there is no evidence to support an advantage in using an epiduroscope with steroid injections (Manchikanti, 2005).

c. Prolotherapy: Also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and phenol, into the ligamentous structures of the low back. Its proponents claim that the inflammatory response to the injections will recruit cytokine growth factors involved in the proliferation of connective tissue, stabilizing the ligaments of the low back when these structures have been damaged by mechanical insults.

i. There is good evidence that prolotherapy alone is not an effective treatment for chronic low back pain ([Cochrane] Dagenais, 2007). There is some evidence that prolotherapy of the sacroiliac (SI) joint is longer lasting, up to 15 months, than intra-articular steroid injections (Kim, 2010). The study was relatively small and long-term blinding was unclear, however all injections were done under fluoroscopic guidance. Indications included a 80 percent reduction in pain from an SI joint injection with local anesthetic, as well as physical findings of SI joint dysfunction. Lasting functional improvement has not been shown and approximately three injections were required. The injections are invasive, and may be painful to the patient.

ii. The use of prolotherapy for low back pain is generally not recommended, as the majority of patients with SI joint dysfunction will do well with a combination of active therapy and manipulation and not require prolotherapy. However, it may be used in select patients. Prolotherapy is not recommended for other non-specific back pain.

d. Radio Frequency Ablation - Dorsal Nerve Root Ganglion: Due to the combination of possible adverse side effects, time limited effectiveness, and mixed study results, this treatment is not recommended. Refer to the Chronic Pain Disorder Medical Treatment Guidelines.

e. Radio Frequency (RF) Neurotomy

i. Description. A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used.

ii. There is good evidence to support Radio Frequency Medial Branch Neurotomy in the cervical spine but benefits beyond one year are not yet established. Evidence in the lumbar spine is conflicting; however, the procedure is generally accepted. In one study, 60 percent of patients maintained at least 90 percent pain relief at 12 months. Radio-frequency Medial Branch Neurotomy RF neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe using fluoroscopic guidance is required because the maximum effective diameter of the device is a 5x8 millimeter oval. Permanent images should be recorded to verify placement of the device.

iii. Needle Placement. Multi-planar fluoroscopic imaging is required for all injections. Injection of contrast dye to assure correct needle placement is required to verify the flow of medication. Permanent images are required to verify needle placement.

iv. Indications. Those patients with proven, significant, facetogenic pain. A minority of low back patients would be expected to qualify for this procedure (Manchikanti, 2004). This procedure is not recommended for patients with multiple pain generators or involvement of more than three levels of medial branch nerves. Individuals should have met all of the following indications:

(a). pain of well-documented facet origin, and;
(b). unresponsive to active and/or passive therapy, and:

(i). it is generally recommended that this procedure not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Therapy-Active);

(c). unresponsive to manual therapy; and
(d). in which a psychosocial evaluation has been performed

(e). All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used.

(i). In almost all cases, this will mean a reduction of pain to 1 or 2 on the 10-point Visual Analog Scale (VAS) correlated with functional improvement. The patient should also identify activities of daily living (ADLs) (which may include measurements of ROM) that are impeded by their pain and can be observed to document objective functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

(ii). A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

v. Complications — Bleeding, infection, or neural injury. The clinician must be aware of the risk of developing a localized neuritis, or rarely, a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures.

vi. Post-Procedure Therapy — Active therapy. Implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-procedure week, barring complications. Instruction and participation in a long-term home-based program of ROM, core strengthening, postural or neuromuscular re-education,

endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

vii. Requirements for Repeat Radiofrequency Medial Branch Neurotomy: (or additional-level RF Neurotomies) In some cases pain may recur. Successful RF Neurotomy usually provides from six to eighteen months of relief.

(a). Before a repeat RF Neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

f. Radio Frequency Neurotomy - Sacro-iliac (SI) Joint Cooled: Sacro-iliac (SI) joint radiofrequency neurotomy is a denervation of the SI joint.

i. This procedure has limited evidence to support efficacy for its use and may be considered for therapeutic purposes.

g. Transdiscal Biacuplasty. A cooled radiofrequency procedure intended to coagulate fissures in the disc and surrounding nerves which could be pain generators. It is not recommended due to lack of published data demonstrating effectiveness (ISIS, 2013).

h. Trigger Point Injections:

i. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of injection of local anesthetic, with or without corticosteroid, into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities.

(a). There is conflicting evidence regarding the benefit of trigger point injections ([Cochrane] Staal, 2008). A truly blinded study comparing dry needle treatment of trigger points is not feasible (See Passive Therapy – Dry Needling). There is no evidence that injection of medications improves the results of trigger-point injections ([Cochrane] Staal, 2008). Needling alone may account for some of the therapeutic response. Needling must be performed by practitioners with the appropriate credentials in accordance with state and other applicable regulations.

(b). There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

ii. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as active therapy programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural

problems and any abnormalities need to be ruled out prior to injection.

(a). For acute exacerbations trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six week time frame. However, trigger point injections may be occasionally effective when utilized in the patient with immediate, acute onset of low back pain.

iii. Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, penetration of viscera, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

iv. Patients should be reassessed after each injection session for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement for three months. A positive result would include a return to base line function, return to increased work duties, and measurable improvement in physical activity goals including return to baseline after an exacerbation.

v. Timing/Frequency/Duration

(a). Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia.

(b). Frequency: Weekly. Suggest no more than four injection sites per session per week to avoid significant post-injection soreness.

(c). Optimum duration: Four weeks.

(d). Maximum duration: Eight weeks. Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

5. Interdisciplinary Rehabilitation Programs. This is the gold standard of treatment for individuals with low back pain who have not responded to less intensive modes of treatment. There is good evidence that interdisciplinary programs which include screening for psychological issues, identification of fear-avoidance beliefs and treatment barriers, and establishment of individual functional and work goals will improve function and decrease disability (Dobscha, 2009; Lambek, 2010). These programs should assess the impact of pain and suffering on the patient's medical, physical, psychological, social, and/or vocational functioning. In general, interdisciplinary programs evaluate and treat multiple and sometimes irreversible conditions, including, but not limited to: painful musculoskeletal, neurological, and other chronic pain conditions and psychological issues; drug dependence, abuse, or addiction; high levels of stress and anxiety; failed surgery; and pre-existing or latent psychopathology. The number of professions involved on the team in a chronic pain program may vary due to the complexity of the needs of the person served. The OWCA recommends consideration of referral to an interdisciplinary program within six months post-injury in patients with delayed recovery, unless successful surgical

interventions or other medical and/or psychological treatment complications intervene.

a. Chronic pain patients need to be treated as outpatients within a continuum of treatment intensity. Outpatient chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated among practices by the authorized treating physician (informal). Formal programs are able to provide a coordinated, high-intensity level of services and are recommended for most chronic pain patients who have received multiple therapies during acute management.

b. Patients with addiction problems, high-dose opioid use, or use of other drugs of abuse may require inpatient and/or outpatient chemical dependency treatment programs before or in conjunction with other interdisciplinary rehabilitation. Guidelines from the American Society of Addiction Medicine are available and may be consulted relating to the intensity of services required for different classes of patients in order to achieve successful treatment.

c. Informal interdisciplinary pain programs may be considered for patients who are currently employed, those who cannot attend all-day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach, methods, and goals. Generally, the type of outpatient program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social, and/or vocational functioning.

d. When referring a patient for formal outpatient interdisciplinary pain rehabilitation, an occupational rehabilitation program, or an opioid treatment program, the OWCA recommends the program meets the criteria of the Commission on Accreditation of Rehabilitation Facilities (CARF).

e. Inpatient pain rehabilitation programs are rarely needed but may be necessary for patients with any of the following conditions: high risk for medical instability; moderate-to-severe impairment of physical/functional status; moderate-to-severe pain behaviors; moderate impairment of cognitive and/or emotional status; dependence on medications from which he/she needs to be withdrawn; and the need for 24-hour supervised nursing.

f. Whether formal or informal programs, they should be comprised of the following dimensions (CARF 2010-11):

i. Communication: To ensure positive functional outcomes, communication between the patient, insurer, and all professionals involved must be coordinated and consistent. Any exchange of information must be provided to all professionals, including the patient. Care decisions should be communicated to all and should include the family and/or support system.

ii. Documentation: Through documentation by all professionals involved and/or discussions with the patient, it should be clear that functional goals are being actively pursued and measured on a regular basis to determine their achievement or need for modification.

iii. Treatment Modalities: Use of modalities may be necessary early in the process to facilitate compliance

with and tolerance to therapeutic exercise, physical conditioning, and increasing functional activities. Active treatments should be emphasized over passive treatments. Active and self-monitored passive treatments should encourage self-coping skills and management of pain, which can be continued independently at home or at work. Treatments that can foster a sense of dependency by the patient on the caregiver should be avoided. Treatment length should be decided based upon observed functional improvement. For a complete list of active and passive therapies, refer to Therapy – Active and Therapy – Passive. All treatment timeframes may be extended based on the patient’s positive functional improvement.

iv. Therapeutic Exercise Programs: A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize education, independence, and the importance of an on-going exercise regimen. There is good evidence that exercise alone or part of a multi-disciplinary program results in decreased disability for workers with non-acute low back pain (Oesch, 2010). There is not sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen.

v. Return to Work: The authorized treating physician should continually evaluate the patient for their potential to return to work. For patients currently employed, efforts should be aimed at keeping them employed. Formal rehabilitation programs should provide assistance in creating work profiles. For more specific information regarding return to work, refer to Return to Work.

vi. Patient Education: Patients with pain need to re-establish a healthy balance in lifestyle. All providers should educate patients on how to overcome barriers to resuming daily activity, including pain management, decreased energy levels, financial constraints, decreased physical ability, and change in family dynamics.

vii. Psychosocial Evaluation and Treatment: Psychosocial evaluation should be initiated, if not previously done. Providers of care should have a thorough understanding of the patient’s personality profile, especially if dependency issues are involved. Psychosocial treatment may enhance the patient’s ability to participate in pain treatment rehabilitation, manage stress, and increase their problem-solving and self-management skills.

viii. Vocational Assistance: Vocational assistance can define future employment opportunities or assist patients in obtaining future employment. Refer to Return to Work for detailed information.

g. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of the treatment program. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. Programs should have sufficient personnel to work with the individual in the following areas: behavior, functional, medical, cognitive, pain management, psychological, social and vocational.

h. Formal Interdisciplinary Rehabilitation Programs:

i. Interdisciplinary Pain Rehabilitation: An Interdisciplinary Pain Rehabilitation Program provides outcome-focused, coordinated, goal-oriented

interdisciplinary team services to measure and improve the functioning of persons with pain and encourage their appropriate use of health care system and services. The program can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. The program shares information about the scope of the services and the outcomes achieved with patients, authorized providers, and insurers.

(a.) The interdisciplinary team maintains consistent integration and communication to ensure that all interdisciplinary team members are aware of the plan of care for the patient, are exchanging information, and implement the plan of care. The team members make interdisciplinary team decisions with the patient and then ensure that decisions are communicated to the entire care team.

(b.) The Medical Director of the pain program should ideally be board certified in pain management; or he/she should be board certified in his/her specialty area and have completed a one-year fellowship in interdisciplinary pain medicine or palliative care recognized by a national board or have two years of experience in an interdisciplinary pain rehabilitation program. Teams that assist in the accomplishment of functional, physical, psychological, social, and vocational goals must include: a medical director, pain team physician(s), and a pain team psychologist. Professionals from other disciplines on the team may include, but are not limited to: a biofeedback therapist, an occupational therapist, a physical therapist, a registered nurse (RN), a case manager, an exercise physiologist, a psychologist, a psychiatrist, and/or a nutritionist.

(c.) Timing/Frequency/Duration:

(i.) Time to Produce Effect: Three to four weeks.

(ii.) Frequency: Full time programs – No less than five hours per day, five days per week; part-time programs – four hours per day, two to three days per week.

(iii.) Optimum Duration: 3 to 12 weeks at least two to three times a week. Follow-up visits weekly or every other week during the first one to two months after the initial program is completed.

(iv.) Maximum Duration: Four months for full-time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, and additional follow-up based on the documented maintenance of functional gains.

ii. Occupational Rehabilitation

(a.) This is a formal interdisciplinary program addressing a patient’s employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full work day. A full work day is case specific and is defined by the previous employment of the patient. Safe workplace practices and education of the employer and family and/or social support system regarding the person’s status should be included. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return to work.

(b.) There is some evidence that an integrated care program, consisting of workplace interventions and graded activity teaching that pain need not limit activity, is effective in returning patients with chronic low back pain to

work, even with minimal reported reduction of pain (Lambeek, 2010).

(c). The occupational medicine rehabilitation interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; an occupational therapist; and a physical therapist.

(d). As appropriate, the team may also include any of the following: chiropractor, an RN, a case manager, a psychologist, a vocational specialist, or a certified biofeedback therapist.

(e). Timing/Frequency/Duration:

(i). Time to Produce Effect: Two weeks.

(ii). Frequency: Two to five visits per week, up to eight hours per day.

(iii). Optimum Duration: Two to four weeks.

(iv). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic and functional gains.

iii. Spinal Cord Programs:

(a) Spinal Cord Systems of Care provide coordinated, case-managed, and integrated services for people with spinal cord dysfunction, whether due to trauma or disease. The system includes an inpatient component in an organization licensed as a hospital, as well as an outpatient component. Each component endorses the active participation and choice of the persons served throughout the entire program. The Spinal Cord System of Care also provides or formally links with key components of care that address the lifelong needs of the persons served.

(b). This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified and trained in rehabilitation, a case manager, an occupational therapist, a physical therapist, a psychologist, a rehabilitation RN and MD/DO, and a therapeutic recreation specialist. As appropriate, the team may also include: a rehabilitation counselor, a respiratory therapist, a social worker, or a speech-language pathologist.

(c). Timeframe durations for any spinal cord program should be determined based on the extent of the patient's injury and at the discretion of the rehabilitation physician in charge.

iv. Opioid/Chemical Treatment Programs: Refer to the Chronic Pain Disorder Medical Treatment Guidelines.

i. Informal Interdisciplinary Rehabilitation Program: A coordinated interdisciplinary pain rehabilitation program is one in which the authorized treating physician coordinates all aspects of care. This type of program is similar to the formal programs in that it is goal-oriented and provides interdisciplinary rehabilitation services to manage the needs of the patient in the following areas: functional, medical, physical, psychological, social, and vocational.

i. This program is different from a formal program in that it involves lower frequency and intensity of services/treatment. Informal rehabilitation is geared toward those patients who do not need the intensity of service

offered in a formal program or who cannot attend an all-day program due to employment, daycare, language, or other barriers.

ii. Patients should be referred to professionals experienced in outpatient treatment of chronic pain. The OWCA recommends the authorized treating physician consult with physicians experienced in the treatment of chronic pain to develop the plan of care. Communication among care providers regarding clear objective goals and progress toward the goals is essential. Employers should be involved in return to work and work restrictions, and the family and/or social support system should be included in the treatment plan. Professionals from other disciplines likely to be involved include: a biofeedback therapist, an occupational therapist, a physical therapist, an RN, a psychologist, a case manager, an exercise physiologist, a psychiatrist, and/or a nutritionist.

iii. Timing/Frequency/Duration:

(a). Time to Produce Effect: Three to four weeks

(b). Frequency: Full time programs - no less than five hours per day, five days per week; Part time programs - four hours per day for two to three days per week.

(c). Duration: 3 to 12 weeks at least two to three times a week. With follow up visits weekly or every other week during the first one to two months after the initial program is completed.

(d). Maximum duration: Four months for full time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, additional follow up based upon the documented maintenance of functional gains.

6. Medications: Use in the treatment of low-back injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries, from simple strains to post-surgical healing. A thorough medication history, including use of alternative and over-the-counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or nonsteroidal anti-inflammatory drugs (NSAIDs). The patient should be educated regarding the interaction of prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The medication lists below do not provide complete information on side effects or drug interactions. Providers should seek information from other sources for details. The following medications are listed in alphabetical order:

a. Acetaminophen: An effective analgesic with anti-pyretic but not anti-inflammatory activity. Acetaminophen is generally well-tolerated, causes little or no gastrointestinal (GI) irritation, and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed three grams per 24-hour period, from all sources, including narcotic-acetaminophen combination preparations.

i. Optimum Duration: 7 to 10 days.

ii. Maximum Duration: Extended use as indicated on a case-by-case basis. Use of this substance long-term (for

three days per week or greater) may be associated with rebound pain upon cessation.

b. Antibiotics for chronic pain secondary to disc herniation: Several studies have documented the presence of bacteria in herniated disc nucleus tissue removed surgically (Stirling, 2001; Corsia, 2003). It had been postulated that Modic type 1 changes could be secondary to bacterial infection. There is good evidence from one study that chronic pain patients with Modic type 1 changes in discs adjacent to the initial disc herniation after six months of treatment can experience decreased pain and disability after a 100 day course of amoxicillin-clavulanate (one or two 500mg/125mg three times per day) (Albert, 2013). Modic type one changes demonstrate decreased intensity on T1 spin echo weighted images and increase intensity on T2 spin echo weighted images. Modic changes consistent with this definition qualify for treatment. The antibiotic course is similar to that prescribed for post-operative discitis. Both non-surgical and surgical patients were included in the study and radicular symptoms could be present or pain could be limited to axial pain. Patients were instructed not to exercise during the treatment period. Most patients reported decreased pain at night and no longer having constant pain. Improvement in pain and disability started at about six weeks, increased over time and persisted at one year. Some patients stopped therapy due to side effects.

i. Complications: include those related to long-term antibiotic therapy.

ii. Indications:

(a). Modic type 1 changes at adjacent vertebra at the time of treatment initiation.

(b). 6 to 24 months of pain with an average of 6/10 (calculate average by using the worst reported pain within the last two weeks, current pain, and usual pain in the last two weeks)

(c). Pain interferes with function, e.g., not able to return to full duty

(d). Use of chronic opioids to control pain

(e). No contraindications to antibiotic use.

c. Intravenous Steroids: The benefits of preventing neurological damage from acute spinal cord compression in an emergent situation generally outweigh the risks of pharmacologic side effects from steroids.

d. Glucosamine: There is good evidence that glucosamine does not improve pain related disability in those with chronic low back pain and degenerative changes on radiologic studies; therefore, it is not recommended for chronic lumbar spinal or non-joint pain (Wilkens, 2010).

e. Muscle Relaxants: Appropriate for muscle spasm with pain. There is strong evidence that non-benzodiazepine muscle relaxants are more effective than placebo for providing short-term pain relief in acute low back pain ([Cochrane] van Tulder, 2003). When prescribing these agents, physicians must seriously consider all central nervous system (CNS) side effects including drowsiness or dizziness and the fact that benzodiazepines may be habit-forming. Carisoprodol should not be used as its active metabolite, meprobamate is commonly abused. Chronic use of benzodiazepines is not recommended due to their habit-forming potential, seizure risk following abrupt withdrawal, and documented contribution to deaths of patients on opioids

due to respiratory depression. A number of muscle relaxants interact with other medications.

i. Optimum Duration: One week.

ii. Maximum Duration: Two weeks (or longer if used only at night).

f. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): Useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case, with the most effective preparation being continued.

i. Patients should be closely monitored for adverse reactions. The FDA advises that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. There is good evidence that naproxen has the least risk for cardiovascular events when compared to other NSAIDs (Trelle, 2011). Administration of proton pump inhibitors, Histamine 2 Blockers or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration in those at higher risk for this adverse event (e.g. age > 60, concurrent antiplatelet or corticosteroid therapy). They do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and it should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Patients with renal or hepatic disease may need increased dosing intervals with chronic acetaminophen use. Chronic use of NSAIDs is generally not recommended due to increased risk of cardiovascular events and GI bleeding.

ii. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent on the patient's age and general health status and should be within parameters listed for each specific medication. Complete blood count (CBC) and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

iii. Non-Selective Non-Steroidal Anti-Inflammatory Drugs:

(a). Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms, in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

(i). Optimal Duration: One week.

(ii). Maximum duration: One year. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

iv. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors:

(a). COX-2 inhibitors differ from the traditional NSAIDs in adverse side effect profiles. The major

advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less GI toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency; thus, renal function may need monitoring.

(b). COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short-term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

(i). Optimal Duration: 7 to 10 days.

(ii). Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

g. Opioids: Should be reserved for the treatment of acute severe low back pain. There are circumstances where prolonged use of opioids is justified based on diagnosis and severity of functional deficits, and in these cases, it should be documented and justified. In mild to moderate cases of low back pain, opioid medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

i. Opioid medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the opioid prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.

(a). Optimum Duration: Three to seven days.

(b). Maximum Duration: Two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines, which give a detailed discussion regarding medication use in chronic pain management. Use beyond 30 days after non-traumatic injuries, or six weeks post-surgery after the original injury or post operatively is not recommended. If necessary the physician should access the Louisiana Prescription Drug Monitoring Program (PDMP) and follow recommendations in Chronic Pain Guideline. This system allows the prescribing physician to see most of the controlled substances prescribed by other physicians for an individual patient.

h. Oral Steroids: Have limited use but are accepted in cases requiring potent anti-inflammatory drug effect. Two studies were identified for the treatment of herniated discs that did not qualify for evidence, however both used comparison placebo groups and neither showed any long-term benefit regarding pain or disability (Holve, 2008; Haimovic, 1986). There is no adequate evidence supporting oral steroids for patients with low back pain with or without radiculopathy, significant side effects are possible, and they are not generally recommended (Hopwood 1993).

i. Psychotropic/Anti-Anxiety/Hypnotic Agents: May be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Antidepressant

medications, such as tricyclics and selective serotonin reuptake inhibitors (SSRIs), are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low doses, are useful for chronic neurogenic pain with difficulty sleeping but have more frequent side effects.

i. Anti-anxiety medications are best used for short-term treatment (i.e., less than six months). Accompanying sleep disorders are best treated with sedating anti-depressants prior to bedtime. Frequently, combinations of the above agents are useful. As a general rule, providers (i.e., physician or medical psychologist) should assess the patient's prior history of substance abuse or depression prior to prescribing any of these agents.

ii. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not generally recommended. Refer to the Chronic Pain Disorder Medical Treatment Guidelines, which give a detailed discussion regarding medication use in chronic pain management.

(a). Optimum Duration: One to six months.

(b). Maximum Duration: 6 to 12 months, with monitoring.

j. Tramadol: May be useful in the relief of low back pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Tramadol is an atypical opioid with norepinephrine and serotonin reuptake inhibition. Tramadol is now classified as a Schedule IV controlled substance (CS) by the DEA. Although tramadol may cause impaired alertness, it is generally well-tolerated, does not cause GI ulceration, and does not exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, SSRIs, some muscle relaxants, and tricyclic antidepressants. Because it inhibits the reuptake of norepinephrine and serotonin, use with other agents that increase norepinephrine and/or serotonin (e.g. SNRIs, mirtazapine, TCAs, SSRIs) can result in serotonin syndrome. This medication has physically addictive properties, and withdrawal may follow abrupt discontinuation; thus, it is not generally recommended for those with prior opioid addiction.

i. Optimum Duration: Three to seven days.

ii. Maximum Duration: Two weeks. Use beyond two weeks is acceptable in appropriate cases.

7. Orthotics

a. Foot Orthoses and Inserts: These are accepted interventions for spinal disorders that are due to aggravated mechanical abnormalities, such as leg length discrepancy, scoliosis, or lower extremity misalignment. Shoe insoles or inserts may be effective for patients with acute low back problems who stand for prolonged periods of time. A trial of taping may be performed first to evaluate the likely effect of an orthotic.

b. Lumbar Support Devices: Include backrests for chairs and car seats. Lumbar supports may provide symptomatic relief of pain and movement reduction in cases of chronic low back problems. Lumbar support devices can be utilized to maintain physiologically correct posture of the spine. Lumbar supports should usually be approximately 1.5" in thickness to maintain the natural lordosis of the

lumbar spine, but may depend on patient size and firmness of support.

c. ...

d. Lumbosacral Bracing: Rigid bracing devices are well-accepted and commonly used for post-fusion, scoliosis, and vertebral fractures. Use of the rigid bracing should generally not exceed twelve weeks secondary to possible de-conditioning of the trunk musculature. Sacroiliac belts may be indicated for short durations to assist with stability of the SI joint

8. Education/Informed Decision Making of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of low back pain and disability. Unfortunately, practitioners often think of education and informed decision making last, after medications, manual therapy, and surgery.

a. Informed decision making is the hallmark of a successful treatment plan. In most cases the continuum of treatment from the least invasive to the most invasive (e.g. surgery) should be discussed. The intention is to find the treatment along this continuum which most completely addresses the condition. Patients should identify their personal functional goals of treatment at the first visit. It is recommended that specific individual goals are articulated at the beginning of treatment as this is likely to lead to increased patient satisfaction above that achieved from improvement in pain or other physical function (Hazard, 2009). There is some evidence that a two day course focusing on the biopsychosocial model with an emphasis on the goals of returning to usual activities and fitness is as effective in reducing disability as six manual therapy sessions provided by physiotherapists and more limited patient education (Hay, 2005). Progress toward the individual functional goals identified should be addressed at follow up-visits and throughout treatment by other members of the health care team as well as the authorized physicians.

b. Documentation of this process should occur whenever diagnostic tests or referrals from the authorized treating physician are contemplated. The informed decision making process asks the patient to set their personal functional goals of treatment, describe their current health status and any concerns they have regarding adhering to the diagnostic or treatment plan proposed. The provider should clearly describe the following.

i. The expected functional outcomes from the proposed treatment, or expected results and plan of action if diagnostic tests are involved.

ii. Any side effects and risks to the patient.

iii. Required post treatment rehabilitation time and impact on work, if any.

iv. Alternative therapies or diagnostic testing.

c. Before diagnostic tests or referrals for invasive treatment take place the patient should be able to clearly articulate the goals of the intervention, the general side effects and risks associated with it and their decision regarding compliance with the suggested plan. One study indicated that information provided only by video might not be sufficient education (Newcomer, 2008).

d. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start

with providing reassuring information to the patient and informed decision making. More in-depth education currently exists within a treatment regimen employing functional restoration, prevention, and cognitive behavioral techniques. Patient education and informed decision making should facilitate self-management of symptoms and prevention.

e. Timing/Frequency

i. Time to produce effect: Varies with individual patient

ii. Frequency: Should occur at every visit.

9. Psychological/Psychosocial Intervention.

a. Psychosocial treatment is a well-established therapeutic and diagnostic intervention with selected use in acute pain problems and more widespread use in sub-acute and chronic pain populations. Psychosocial treatment is recommended as an important component in the total management of a patient with chronic low back pain and should be implemented as soon as the problem is identified.

b. If a diagnosis consistent with the standards of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) has been determined, the patient should be evaluated for the potential need for psychiatric medications. Use of any medication to treat a diagnosed condition may be ordered by the authorized treating physician or by the consulting psychiatrist. Visits for management of psychiatric medications are medical in nature and are not a component of psychosocial treatment. Therefore, separate visits for medication management may be necessary, depending on the patient and medications selected.

c. Psychosocial interventions include psychotherapeutic treatments for mental health conditions, as well as behavioral medicine treatments. These interventions may similarly be beneficial for patients without psychiatric conditions, but who may need to make major life changes in order to cope with pain or adjust to disability. Examples of these treatments include cognitive behavioral therapy (CBT), relaxation training, mindfulness training, and sleep hygiene training.

d. The screening or diagnostic workup should clarify and distinguish between pre-existing, aggravated, and/or purely causative psychological conditions. Therapeutic and diagnostic modalities include, but are not limited to, individual counseling and group therapy. Treatment can occur within an individualized model, a multi-disciplinary model, or a structured pain management program.

e. A licensed psychologist or a psychiatric MD/DO may perform psychosocial treatments. Other licensed mental health providers or licensed health care providers with training in CBT, or certified as CBT therapists who have experience in treating chronic pain disorders in injured workers, may also perform treatment in consultation with a licensed psychologist or psychiatric MD/DO.

f. CBT refers to a group of psychological therapies that are sometimes referred to by more specific names, such as Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy. Variations of CBT methods can be used to treat a variety of conditions, including chronic pain, depression, anxiety, phobias, and post-traumatic stress

disorder (PTSD). For patients with multiple diagnoses, more than one type of CBT might be needed. The CBT used in research studies is often “manualized CBT,” meaning that the treatment follows a specific protocol in a manual (Thorn, 2004). In clinical settings, CBT may involve the use of standardized materials, but it is also commonly adapted by a psychologist or psychiatrist to the patient’s unique circumstances. If the CBT is being performed by a non-mental health professional, a manual approach would be strongly recommended. CBT must be distinguished from neuropsychological therapies used to teach compensatory strategies to brain injured patients, which are also called “cognitive therapy.”

g. It should be noted that most clinical trials on CBT exclude subjects who have significant psychiatric diagnoses. Consequently, the selection of patients for CBT should include the following considerations. CBT is instructive and structured, using an educational model with homework to teach inductive rational thinking. Because of this educational model, a certain level of literacy is assumed for most CBT protocols. Patients who lack the cognitive and educational abilities required by a CBT protocol are unlikely to be successful. Further, given the highly structured nature of CBT, it is more effective when a patient’s circumstances are relatively stable. For example, if a patient is about to be evicted, is actively suicidal, or is coming to sessions intoxicated, these matters will generally preempt CBT treatment for pain, and require other types of psychotherapeutic response. Conversely, literate patients whose circumstances are relatively stable, but who catastrophize or cope poorly with pain or disability are often good candidates for CBT for pain. Similarly, literate patients whose circumstances are relatively stable, but who exhibit unfounded medical phobias, are often good candidates for CBT for anxiety.

h. There is good evidence that cognitive intervention reduces low back disability in the short term and in the long term. In one of the studies the therapy consisted of six two-hour sessions given weekly to workers who had been sick-listed for 8 to 12 weeks. Comparison groups included those who received routine care (Storheim, 2003; Linton, 2005). There is good evidence that psychological interventions, especially CBT, are superior to no psychological intervention for chronic low back pain, and that self-regulatory interventions, such as biofeedback and relaxation training, may be equally effective (Hoffman, 2007). There is good evidence that six group therapy sessions lasting one and a half hours each focused on CBT skills improved function and alleviated pain in uncomplicated sub-acute and chronic low back pain patients (Lamb, 2010). There is some evidence that CBT provided in seven two-hour small group sessions can reduce the severity of insomnia in chronic pain patients (Currie, 2000). A Cochrane meta-analysis grouped very heterogeneous behavioral interventions and concluded that there was good evidence that CBT may reduce pain and disability but the effect size was uncertain ([Cochrane] Eccleston, 2009). In total, the evidence clearly supports CBT, and it should be offered to all chronic pain patients who do not have other serious issues, as discussed above.

i. CBT is often combined with active therapy in an interdisciplinary program, whether formal or informal. It

must be coordinated with a licensed psychologist or psychiatrist. CBT can be done in a small group or individually, and the usual number of treatments varies between 8 and 16 sessions.

j. Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or psychiatric MD/DO.

k. Psychological Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis I disorders are common in chronic pain. One study demonstrated that the majority of patients who had failed other therapy and participated in an active therapy program also suffered from major depression. However, in a program that included CBT and other psychological counseling, the success rate for return to work was similar for those with and without a DSM IV diagnosis. This study further strengthens the argument for having some psychological intervention included in all chronic pain treatment plans (Gatchel, 1994).

l. For all psychological/psychiatric interventions, an assessment and treatment plan with measurable behavioral goals, time frames, and specific interventions planned, must be provided to the treating physician prior to initiating treatment. A status report must be provided to the authorized treating physician every two weeks during initial more frequent treatment and monthly thereafter. The report should provide documentation of progress toward functional recovery and a discussion of the psychosocial issues affecting the patient’s ability to participate in treatment. The report should also address pertinent issues such as pre-existing, aggravated, and/or causative issues, as well as realistic functional prognosis.

m. Cognitive Behavioral Therapy (CBT) or Similar Treatment: Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or Psychiatric MD/DO.

i. Timing/Duration

(a). Time to Produce Effect: six to eight 1–2 hour session, group or individual (one-hour individual or two-hour group).

(b). Maximum Duration: 16 sessions.

n. Other Psychological/Psychiatric Interventions:

i. Timing/Frequency/Duration

(a). Time to Produce Effect: Six to eight weeks.

(b). Frequency: One to two times weekly for the first two weeks (excluding hospitalization, if required), decreasing to one time per week for the second month. Thereafter, two to four times monthly with the exception of exacerbations, which may require increased frequency of visits. Not to include visits for medication management

(c). Optimum Duration: Two to six months.

(d). Maximum Duration: Six months. Not to include visits for medication management. For select patients, longer supervised psychological/psychiatric treatment may be required, especially if there are ongoing medical procedures or complications. If counseling beyond six months is indicated, the management of psychosocial risks or functional progress must be documented. Treatment plan/progress must show severity.

10. Restriction of Activities. Continuation of normal daily activities is the recommendation for low back pain

patients since immobility will negatively affect rehabilitation. Prolonged immobility results in a wide range of deleterious effects, such as a reduction in aerobic capacity and conditioning, loss of muscle strength and flexibility, increased segmental stiffness, promotion of bone demineralization, impaired disc nutrition, and the facilitation of the illness role.

a. Immobility may range from bed rest to the continued use of orthotics, such as lumbar support braces. While these interventions may occasionally have been ordered in the acute phase, the provider should be aware of their impact on the patient's ability to adequately comply with and successfully complete rehabilitation. There is strong evidence against the use of bed rest in acute low back pain cases without neurologic symptoms (Hagen, 2000; Malmivaara, 1995). Activity should be increased based on the improvement of core strengthening.

b. Patients should be educated regarding the detrimental effects of immobility versus the efficacious use of limited rest periods. Adequate rest allows the patient to comply with active treatment and benefit from the rehabilitation program. In addition, complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation and promotes disability. Modified return to work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with low back pain.

11. Return to Work: Return to work and/or work-related activities whenever possible is one of the major components in low back pain management and rehabilitation. There is some evidence that an integrated care program including workplace interventions and graded activity teaching that pain need not limit activity is effective in returning patients with chronic low back pain to work, even with minimal reduction of pain (Lambeek, 2010). Return to work is a subject that should be addressed by each workers' compensation provider at the first meeting with the injured employee and updated at each additional visit. A return-to-work format should be part of a company's health plan, knowing that return to work can decrease anxiety, reduce the possibility of depression, and reconnect the worker with society.

a. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset. In complex cases, experienced nurse case managers may be required to assist in return to work. Other services, including psychological evaluation and/or treatment, jobsite analysis, and vocational assistance, may be employed.

b. Two counseling sessions with an occupational physician, and work site visit if necessary, may be helpful for workers who are concerned about returning to work (Jensen, 2012b). Another study found that low back pain claimants who received information on self-care and return to work had fewer episodes of relapse than those who did not receive the advice (DuBois, 2012).

c. At least one study suggests that health status is worse for those who do not return to work than those who do. Self-employment and injury severity predict return to work. Difficulty with pain control, ADLs, and anxiety and depression were common (Kendrick, 2012).

d. The following should be considered when attempting to return an injured worker with chronic pain to work.

i. Job History Interview: The authorized treating physician should perform a job history interview at the time of the initial evaluation and before any plan of treatment is established. Documentation should include the workers' job demands, stressors, duties of current job, and duties of job at the time of the initial injury. In addition, cognitive and social issues should be identified, and treatment of these issues should be incorporated into the plan of care.

ii. Coordination of Care: Management of the case is a significant part of return to work and may be the responsibility of the authorized treating physician, occupational health nurse, risk manager, or others. Case management is a method of communication between the primary provider, referral providers, insurer, employer, and employee. Because case management may be coordinated by a variety of professionals, the case manager should be identified in the medical record.

iii. Communication: This is essential between the patient, authorized treating physician, employer, and insurer. Employers should be contacted to verify employment status, job duties and demands, and policies regarding injured workers. In addition, the availability and duration of temporary and permanent restrictions, as well as other placement options, should be discussed and documented. All communications in the absence of the patient are required to be documented and made available to the patient.

iv. Establishment of Return-to-Work Status: Return to work for persons with chronic pain should be considered therapeutic, assuming that work is not likely to aggravate the basic problem or increase the discomfort. In most cases of chronic pain, the worker may not be currently working or even employed. The goal of return to work would be to implement a plan of care to return the worker to any level of employment with the current employer or to return him/her to any type of new employment.

v. Establishment of Activity Level Restrictions: A formal job description for the injured worker is necessary to identify physical demands at work and assist in the creation of modified duty. A jobsite evaluation may be utilized to identify applicable tasks such as pushing, pulling, lifting, reaching, grasping, pinching, sitting, standing, posture, ambulatory distance and terrain, and if applicable, environment for temperature, air flow, noise, and the number of hours that may be worked per day. Due to the lack of predictability regarding exacerbation of symptoms affecting function, an extended, occupationally focused functional capacity evaluation may be necessary to determine the patient's tolerance for job type tasks over a continued period of time. Job requirements should be reviewed for the entire eight hours or more of the working day. Between one and three days after the evaluation, there should be a follow-up evaluation by the treating therapist and/or the authorized treating physician to assess the patient's status. When prescribing the FCE, the physician must assess the probability of return to work against the potential for exacerbation of the work related condition. Work restrictions assigned by the authorized treating physician may be temporary or permanent. The case manager should continue to seek out modified work until restrictions become less

cumbersome or as the worker's condition improves or deteriorates

vi. Rehabilitation and Return to Work: As part of rehabilitation, every attempt should be made to simulate work activities so that the authorized treating physician may promote adequate job performance. The use of ergonomic or adaptive equipment, therapeutic breaks, and interventional modalities at work may be necessary to maintain employment.

vii. Vocational Assistance: Formal vocational rehabilitation is a generally accepted intervention and can assist disabled persons to return to viable employment. Assisting patients to identify vocational goals will facilitate medical recovery and aid in the achievement of MMI by (1) increasing motivation towards treatment and (2) alleviating the patient's emotional distress. Chronic low back pain patients will benefit most if vocational assistance is provided during the interdisciplinary rehabilitation phase of treatment. To assess the patient's vocational capacity, a vocational assessment utilizing the information from occupational and physical therapy assessments may be utilized to identify rehabilitation program goals, as well as optimize both patient motivation and utilization of rehabilitation resources. This may be extremely helpful in decreasing the patient's fear regarding an inability to earn a living, which can add to his/her anxiety and depression.

viii. Recommendations to Employers and Employees of Small Businesses: employees of small businesses who are diagnosed with chronic pain may not be able to perform any jobs for which openings exist. Temporary employees may fill those slots while the employee functionally improves. Some small businesses hire other workers, and if the injured employee returns to the job, the supervisor/owner may have an extra employee. To avoid this, it is suggested that case managers be accessed through their payer or third-party administrator. Case managers may assist with resolution of these problems, as well as assist in finding modified job tasks, or find jobs with reduced hours, etc., depending on company philosophy and employee needs.

ix. Recommendations to Employers and Employees of Mid-sized and Large Businesses: Employers are encouraged by OWC to identify modified work within the company that may be available to injured workers with chronic pain who are returning to work with temporary or permanent restrictions. To assist with temporary or permanent placement of the injured worker, it is suggested that a program be implemented that allows the case manager to access descriptions of all jobs within the organization.

12. Therapy – Active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. A retrospective cohort study suggests that early referral to rehabilitation/physical therapy, within 14 days decreases the cost and likelihood of the need for later referrals and testing, thus decreasing overall medical costs (Fritz, 2012). Active therapies are based on the philosophy that therapeutic exercise and/or activities are beneficial for restoring flexibility, strength, endurance, function, ROM, and alleviating discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a licensed or registered occupational or

physical therapist or medical provider. The supervision may include verbal, visual, and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a. Education and counseling should include understanding of the strength inherent in the human spine, and stabilization musculature including the transversus abdominis and multifidus, how neuroscience explains pain perception, the favorable prognosis of low back pain, use of active pain coping strategies that decrease fear and catastrophizing, early resumption of normal activities while still experiencing pain, and the importance of increasing activity levels. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels (Delitto, 2012). Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The patient's baseline and progress should be measured using validated tools such as the Oswestry Disability Index or the Roland –Morris Disability Questionnaire or following objective functional measurements (Delitto, 2012).

b. Therapists should notify the authorized treating physician when clinical findings suggest serious medical or psychological pathology, reported activity limitations are not consistent with the diagnosis, or symptoms are not improving subjectively or objectively after four weeks or resolving with interventions focused on normalizing body function. Various means can be used to measure the functional success of treatment; however, it appears that an increase of 5kg lifting or seven points on the pain disability index may be useful (Gross, 2012).

c. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" have been completed, then alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

d. The following active therapies are listed in alphabetical order:

i. Activities of Daily Living (ADLs): Well-established interventions that involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities, such as self-care, work re-integration training, homemaking, and driving.

(a). Timing/Frequency/Duration:

(i). Time to Produce Effect: Four to five treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

ii. Aquatic Therapy: A well-accepted treatment that consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, ROM, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

- (a). Cannot tolerate active land-based or full-weight bearing therapeutic procedures;
- (b). Require increased support in the presence of proprioceptive deficit;
- (c). Are at risk of compression fracture due to decreased bone density;
- (d). Have symptoms that are exacerbated in a dry environment;
- (e). Have a higher probability of meeting active therapeutic goals than in a dry environment.
- (f). The pool should be large enough to allow full extremity range of motion and fully erect posture. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

(g). Timing/Frequency/Duration

- (i). Time to Produce Effect: Four to five treatments.
- (ii). Frequency: Three to five times per week.
- (iii). Optimum Duration: Four to six weeks.
- (iv). Maximum Duration: Six weeks.
- (h). A self-directed program is recommended after the supervised aquatics program has been established. Best practice suggests that the patient be transitioned to a dry environment exercises which may or may not be self-directed, after four to six weeks unless vocation involves significant time in the water. The transition to dry land may evolve over the course of weeks.

iii. Back Schools: These usually consist of an educational and skills acquisition program, including exercises, in which all lessons are delivered to groups of participants and supervised by a paramedical therapist or medical specialist. There is some evidence of a modest benefit from adding a back school to other treatments such as NSAIDs, massage, transcutaneous electrical nerve stimulation (TENS), and other physical therapy modalities ([Cochrane] Heymans, 2004). When prescribed, back schools should be initiated in the early phases of treatment.

iv. Functional Activities: These are well-established interventions that involve the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(a). Timing/Frequency/Duration

- (i). Time to Produce Effect: Four to five treatments.
- (ii). Frequency: Three to five times per week.
- (iii). Optimum Duration: Four to six weeks.
- (iv). Maximum Duration: Six weeks

v. Functional Electrical Stimulation: This is an accepted treatment in which the application of electrical current elicits involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy in the limbs due to a radiculopathy.

(a). Timing/Frequency/Duration

- (i). Time to Produce Effect: Two to six treatments.
- (ii). Frequency: Three times per week.
- (iii). Optimum Duration: Eight weeks.
- (iv). Maximum Duration: Eight weeks. If beneficial, provide with home unit.

vi. Neuromuscular Re-education: It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception, kinesthetic sense, and coordination; and education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(a). Spinal stabilization is a generally well-accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(b). Timing/Frequency/Duration

- (i). Time to Produce Effect: Four to eight treatments.
- (ii). Frequency: Three times per week.
- (iii). Optimum Duration: Four to eight weeks.
- (iv). Maximum Duration: Eight weeks

vii. Therapeutic Exercise: Therapeutic exercise with or without mechanical assistance or resistance may include the following: isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength; improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception, and coordination, and increased range of motion.

(a). There is some evidence that intensive exercise coupled with cognitive behavioral therapy (CBT) is as effective for chronic un-operated low back pain as posterolateral fusion (Brox, 2010). There is good evidence that exercise alone or as part of a multi-disciplinary program results in decreased disability for workers with non-acute low back pain (Oesch, 2010, [BMJ Clinical Evidence] Chou, 2012).

(b). Therapeutic exercise programs should be specific to the injury and address general functional deficits as identified in the diagnosis and clinical assessment. Patients should be instructed in and receive a home exercise program that is progressed as their functional status improves. Upon discharge, the patient should be independent

in the performance of the home exercise program and should have been educated in the importance of continuing such a program. Educational goals include the development of strategies to maintain or further improve function and to minimize the risk for aggravation of symptoms in the future.

(c). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to eight weeks and concurrent with an active daily home exercise program.

(iv). Maximum Duration: 12 weeks of therapist oversight. Home exercise should continue indefinitely.

(d). Other movement therapy which may be included in therapeutic exercise includes yoga and other alternative exercise therapy supervised by a physician or other appropriate health care professional. Yoga emphasizing structural alignment and postural tolerances is recommended for patients who prefer yoga. There is some evidence that Iyengar restorative yoga, which avoids back bending, results in improved function and decreased chronic mechanical low back pain (Williams, 2009). There is some evidence that yoga emphasizing mobility, strength, and posture to relieve pain may be more effective than usual care for chronic and recurrent low back pain (Tilbrook, 2011). There is strong evidence that yoga has small to moderate advantages over an educational booklet only in reducing low back pain and back specific disability but no evidence that yoga is superior to stretching and strengthening classes led by a physical therapist (Cramer, 2013; Sherman, 2011; Tekur, 2008). The referring health care provider must assure that the instructor has been working with individuals with back pain and is aware of the diagnosis and any activity or positional intolerances. Yoga may be an option for motivated patients whose primary functional goal involves improving positional tolerances.

(i). Timing/Frequency/Duration

[a]. Time to Produce Effect: Six to eight private or small group sessions.

[b]. Frequency: Three to five times per week with daily home practice.

[c]. Optimum Duration: Six to eight weeks of classes and concurrent with an active daily home exercise program.

[d]. Maximum Duration: 8 to 10 weeks of therapist oversight. Home exercise should continue indefinitely.

viii. Work Conditioning: These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuro-musculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of both active and passive, in conjunction with therapeutic exercise, functional activities, general conditioning, body mechanics, and lifting techniques re-training. These programs are

usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(a). Timing/Frequency/Duration

(i). Length of Visit: One to two hours per day.

(ii). Frequency: Two to five visits per week.

(iii). Optimum Duration: Two to four weeks.

(iv). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ix. Work Simulation: Work simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a functional capacity evaluation (FCE) and/or jobsite analysis.

(a). Timing/Frequency/Duration

(i). Length of Visit: One to six hours per day.

(ii). Frequency: Two to five visits per week.

(iii). Optimum Duration: Two to four weeks.

(iv). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

13. Therapy—passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation, and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies, such as postural stabilization and exercise programs to help control swelling, pain, and inflammation during the active rehabilitation process. Please refer to Therapy - Active. Passive therapies may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. ...

b. The following passive therapies are listed in alphabetical order.

i. Electrical Stimulation (Unattended): An accepted treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include muscle spasm, atrophy, and the need for osteogenic stimulation. A home unit should be purchased if treatment is effective, and frequent use is recommended.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Varies, depending upon indication, between two to three times per day to one time per week. Home unit should be purchased if treatment is effective, and frequent use is recommended.

(iii). Optimum Duration: Four treatments for clinic use.

(iv). Maximum Duration: Eight treatments for clinic use.

ii. Intramuscular Manual Therapy: Trigger Point Dry Needling: IMT involves using filament needles to treat "Trigger Points" within muscle. It may require multiple advances of a filament needle to achieve a local twitch response to release muscle tension and pain. Dry needling is an effective treatment for acute and chronic pain of neuropathic origin with very few side effects. Dry needling is a technique to treat the neuro-musculoskeletal system based on pain patterns, muscular dysfunction and other orthopedic signs and symptoms.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Immediate

(ii). Frequency: One to two times per week.

(iii). Optimum Duration: Six weeks.

(iv). Maximum Duration: Eight weeks.

iii. Iontophoresis: There is no proven benefit for this therapy in the low back. Not recommended due to lack of evidence in the lumbar spine.

iv. Low Level Laser: Not recommended as there is no proven benefit for this intervention due to lack of studies of sufficient quality. There is not enough research at this time to support this modality in the treatment of lower back (lumbar) injuries. Results of Low Level Laser have been mixed and often of poor quality.

v. Manipulation: Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease and has associated clinical significance.

(a). For acute low back pain, there is good evidence that manipulation does not have a clinically greater therapeutic effect on acute, six weeks or less, nonspecific low back pain than other interventions including physical therapy (Rubinstein, 2012).

(b). For subacute/chronic pain, there is some evidence that manipulation/mobilization, including thrust techniques, may provide additional benefits on pain and function when used to supplement an individually tailored exercise program (Aure, 2003). There is good evidence that two sessions of thrust manipulation of the thoracolumbar spine followed by an exercise regimen leads to better low back function at six months than oscillatory non-thrust manipulation in patients with subacute low back pain. The study found patients with the following characteristics were likely to benefit from the program: segmental hypomobility, no symptoms distal to the knee, low fear-avoidance scores, and preservation of at least 35 degrees of internal rotation in at least one hip (Cleland, 2009).

(c). There is some evidence that manual therapy, followed by active exercises, may be effective for the reduction of disability from nonspecific low back pain

lasting more than 12 weeks (Balthazard, 2012). There is good evidence that spinal manipulative therapy (SMT) is comparable to exercise, standard medical care, and physiotherapy in reducing chronic low back pain, and good evidence that that SMT does not provide a clinically important superior pain relief over these interventions (Rubinstein, 2011).

(d). The decision to refer a patient for spinal manipulation rather than for other treatments should be made on the basis of patient preference and relative safety, not on an expectation of a greater treatment effect. It may be the first line of treatment, in combination with active therapy for some patients and should strongly be considered for patients with positive provocative testing for SI joint dysfunction (Laslett, 2005) or facet dysfunction who are not recovering in the first few weeks. Manipulation may be indicated in patients who have not had an evaluation for manual medicine, or who have not progressed adequately in an exercise program.

(e). Manipulative treatments may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical doctors (M.D.). Some popular and useful techniques include, but are not limited to, high velocity, low amplitude (HVLA), muscle energy (ME), strain-counterstrain, a balanced ligamentous tension (BLT) and myofascial release (MFR). Under these different types of manipulation exists many subsets of techniques that can be described as: (a) direct- a forceful engagement of a restrictive/pathologic barrier, (b) indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier, (c) the patient actively assists in the treatment and (d) the patient relaxing, allowing the practitioner to move and balance the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body, including muscles, tendons, ligaments, joints, fascia, and viscera. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment are employed.

(f). Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

(g). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to six treatments.

(ii). Frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks. For further treatments, twice per week or less to maintain function;

(iii). Optimum Duration: Eight weeks.

(iv). Maximum Duration: Eight weeks. At week eight, patients should be re-evaluated.

[a]. Care beyond eight weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. In these cases, treatment may be continued at one treatment every other week until

the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co-morbidities. Such care should be re-evaluated and documented on a monthly basis.

vi. Manipulation under General Anesthesia (MUA): Refers to manual manipulation of the lumbar spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for their use. There have been no high-quality studies to justify its benefits given the risks of general anesthetic and conscious sedation. It is not recommended.

vii. Manipulation under Joint Anesthesia (MUJA): Refers to manipulation of the lumbar spine in combination with a fluoroscopically guided injection of anesthetic, with or without corticosteroid agents, into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

viii. Massage – Manual or Mechanical: Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups, and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioners’ hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and ROM, or the need to increase muscle relaxation and flexibility prior to exercise.

(a). There is good evidence that massage therapy in combination with exercise reduces pain and improves function short-term for patients with sub-acute low back pain (Brosseau, 2012; Cherkin, 2001; Furlan, 2008; Preyde, 2000). There is some evidence that massage may be beneficial for low back pain, especially when combined with exercise ([Cochrane] Furlan, 2008). It is required that all massage be performed by trained, experienced therapists, overseen and evaluated by the authorized treating physician and best practice suggests that the modality is accompanied by an active exercise program and patient education. In contrast to the sub-acute population, massage is a generally accepted treatment for the acute low back pain population, although no studies have demonstrated its efficacy for this set of patients.

(b). Timing/Frequency/Duration

- (i). Time to Produce Effect: Immediate.
- (ii). Frequency: One to two times per week.
- (iii). Optimum Duration: Six weeks.
- (iv). Maximum Duration: Eight weeks.

ix. Mobilization (Joint): Mobilization is a passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver.

(a). For acute low back pain, there is good evidence that manipulation does not have a clinically greater therapeutic effect on acute, six weeks or less, nonspecific

low back pain than other interventions including physical therapy (Rubinstein, 2012).

(b). For subacute/chronic pain, there is some evidence that manipulation/mobilization, including thrust techniques, may provide additional benefits on pain and function when used to supplement an individually tailored exercise program (Aure, 2003). There is good evidence that two sessions of thrust manipulation of the thoracolumbar spine followed by an exercise regimen leads to better low back function at six months than oscillatory non-thrust manipulation in patients with subacute low back pain. The study found patients with the following characteristics were likely to benefit from the program: segmental hypomobility, no symptoms distal to the knee, low fear-avoidance scores, and preservation of at least 35 degrees of internal rotation in at least one hip (Cleland, 2009).

(c). There is some evidence that manual therapy, followed by active exercises, may be effective for the reduction of disability from nonspecific low back pain lasting more than 12 weeks (Balthazard, 2012).

(d). There is good evidence that spinal manipulative therapy (SMT) is comparable to exercise, standard medical care, and physiotherapy in reducing chronic low back pain, and good evidence that that SMT does not provide a clinically important superior pain relief over these interventions (Rubinstein, 2011).

(e). There is some evidence that a two day course focusing on the biopsychosocial model with an emphasis on the goals of returning to usual activities and fitness is as effective in reducing disability as six sessions of manual therapy sessions provided by physiotherapists and more limited patient education (Hay, 2005).

(f). For further discussion on grade V joint mobilization, please see the section on high velocity low amplitude (HVLA) manipulation (refer to Manipulation). It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, and intracapsular arthrokinematics, or the need to reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy.

(g). Grade V mobilization contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

(h). Timing/Frequency/Duration

- (i). Time to Produce Effect: Six to nine treatments.
- (ii). Frequency: Up to three times per week.
- (iii). Optimum Duration: Four to six weeks.
- (iv). Maximum Duration: Six weeks.

x. Mobilization (Soft Tissue): A generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and

neural compression. Best practice suggests that mobilization should be accompanied by active therapy.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to nine treatments.

(ii). Frequency: Up to three times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

xi. Short-Wave Diathermy: An accepted treatment that involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced re-absorption of hemorrhage/hematoma or edema. Best practice suggests that this modality be accompanied by active therapy.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Two to three times per week; up to three weeks.

(iii). Optimum Duration: Three to five weeks.

(iv). Maximum Duration: Five weeks.

xii. Superficial Heat and Cold Therapy (excluding Infrared Therapy): A generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, the need to increase pain threshold, the need to reduce muscle spasm, and the need to promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Immediate;

(ii). Frequency: Two to five times per week;

(iii). Optimum Duration: Three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to eight weeks;

(iv). Maximum Duration: Eight weeks.

xiii. Traction – Manual: This is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation. Best practice suggests that this modality be accompanied by active therapy.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to three sessions.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: 30 days.

(iv). Maximum Duration: One month.

xiv. Traction – Mechanical: There is good evidence that mechanical traction is not useful for low back pain patients without radicular symptoms ([Cochrane] Clarke,

2007). Therefore, it is not recommended in this population. It may be trialed in patients with radicular findings, and if successful, should be shifted to home traction. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home lumbar traction unit can be purchased if therapy proves effective:

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to three sessions up to 30 minutes. If response is negative after three treatments, discontinue this modality;

(ii). Frequency: Two to three times per week. A home lumbar traction unit can be purchased if therapy proves effective

(iii). Optimum Duration: Four weeks;

(iv). Maximum Duration: Four weeks.

xv. Transcutaneous Electrical Nerve Stimulation (TENS): Interferential squared wave with microcurrent, usually with four channels. A generally accepted treatment. TENS should include at least one instructional session for proper application and home use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width, and amplitude modulation. Consistent, measurable functional improvement must be documented prior to the purchase of a home unit.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Immediate

(ii). Frequency: Variable.

(iii). Optimum Duration: Three sessions.

(iv). Maximum Duration: Three sessions. If beneficial, provide with home unit or purchase if effective.

xvi. Ultrasound (including phonophoresis). There is no proven benefit for this therapy in the low back. Not recommended due to lack of evidence in the lumbar spine.

xvii. Vertebral Axial Decompression (VAX-D)/DRX, 9000: Motorized traction devices that purport to produce non-surgical disc decompression by creating negative intradiscal pressure in the disc space; included are devices with the trade names VAX-D and DRX 9000. There are no quality randomized studies to support their use. They are not recommended. A report of a case in which a herniated disc progressed while using VAX D is of some concern (Deen, 2003). The proposed mechanism involves the some active back muscle response which can be created by passive traction and may increase disc pressure (Andersson, 1983).

14. Vocational Rehabilitation. This is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification of highest functional level, motivation, and achievement of maximum medical improvement (MMI). Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

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§2023. Therapeutic Procedures—Operative

A. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests, resulting in a reasonable likelihood of at least a measurable and meaningful functional and symptomatic improvement. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s) and in most cases a specific site of nerve root compression, spinal cord compression, or spinal instability. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., psychological conditions, peripheral neuropathy, myofascial pain, rheumatologic, or other pain syndromes, etc.) prior to consideration of elective surgical intervention.

B. Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention. (Donelson, 2012; Skytte, 2005). Patients who demonstrate centralization on directional preference testing may not need surgery when treated with directional preference neuromuscular educations (May, 2012). Refer to Therapeutic Exercise.

C. While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of lumbar pain disorders, an accurate diagnosis and timely decision making for operative intervention are critical. Thorough neurologic exams should be performed periodically to assure timely treatment; to avoid de-conditioning and increased disability and to treat emergent pathology or neurologically compromising conditions which may require early surgery.

D. Brief psychological screening tools, or more frequently full evaluations, are done to predict surgical success (Trief, 2000; Daubs, 2011). Psychological screening is indicated for all patients with continuing pain who are considering surgical interventions as indicated in the MTG under the specific surgical procedure. Lower patient satisfaction after repeat surgical procedures and other treatment are related to pre-existing depression (Adogwa, 2013; Desai, 2005; Haviland, 2003).

E. In general, if the program of non-operative treatment fails, operative treatment is indicated when symptoms and findings suggest a surgically amenable problem and:

1. Improvement of the symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active therapy and manual treatment (mere passage of time with poorly guided treatment is not considered an active treatment program). In cases of myelopathy and some cases of severe nerve root compression, earlier intervention is indicated; or

2. Frequent recurrences of symptoms cause serious functional limitations, even if a non-operative active

treatment program provides significant improvement of symptoms, and restoration of function on each recurrence; and

3. There are some clinical scenarios which necessitate surgical interventions. Surgical workup and implementation of decompression of patients with herniated nucleus pulposus and radiculopathy should occur within 6 to 12 weeks, at the latest, after injury within the above stated contingencies. Small herniations and most protrusions are often not pain generators, however small foraminal disc herniations are likely to compress the nerve root and may require surgical removal.

4. In order to qualify for surgery for nerve root compression, the patient should exhibit the following signs of radiculopathy before invasive procedures are considered:

a. pain in the legs greater than in the low back which interferes with function, return to work and/or active therapy; and

b. physical exam findings of abnormal reflexes, motor weakness or radicular sensation deficits; and

c. findings on the MRI which indicate impingement of nerves or the spinal cord corresponding to reproducible physical exam findings.

5. Treatment of myelopathy may occur earlier. Surgical procedures should be directed toward neurological findings which correlate with MRI imaging. For the unusual patients with refractory lumbar pain in whom fusion is being considered, it is strongly recommended that a decisive commitment to surgical or non-surgical interventions occur within five months following injury.

6. Re-operation is indicated only when the functional outcome following the re-operation is expected to be better, within a reasonable degree of certainty, than the outcome of other non-invasive or less invasive treatment procedures. "Functional outcomes" refer to the patient's ability to improve functional tolerances such as standing, walking, strength, endurance, functional lumbar range of motion, and/or vocational status. While timely surgical decision-making is critical to avoid de-conditioning and increased disability, a time limited trial of reconditioning should be tried prior to re-operation. Re-operation has a high rate of complications and failure and may lead to disproportionately increased disability.

a. For all spinal procedure reoperations, a psychosocial evaluation must be completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention.

7. Every post-operative patient should be involved in an active treatment program after clearance by the surgeon (refer to Therapy – Active). Interdisciplinary interventions should be strongly considered post-operatively in any patient not making functional progress within expected time frames (refer to Interdisciplinary Rehabilitation Programs).

8. Referral for surgical evaluation and treatment. Consultation should be made to an appropriate surgical specialist for surgical evaluation and treatment when operative treatment is considered.

a. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon.

b. Informed decision making should be documented for all invasive procedures. This must include a thorough discussion of the pros and cons of the procedure and the possible complications as well as the natural history of the identified diagnosis. Since most patients with the most common conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment

c. The patient and treating physician have identified functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities. The patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative treatment required and the length of partial- and full-disability expected post-operatively. The patient should have committed to the recommended post-operative treatment plan and fully completed the recommended active, manual and pre-operative treatment plans.

9. Return to work restrictions should be specific according to the recommendations in Return to Work. Most surgical patients can return to a limited level of duty between three to six weeks. Full activity is generally achieved between three months to one year, depending on the procedure, the type of duties performed, and healing of the individual. Patient should be informed of expected time off work.

F. Lumbar Operative Procedures and Conditions

1. Discectomy usually accompanied by partial laminectomy

a. Description: To enter into and partially remove the disc. May be an open procedure or minimally invasive, and usually involves partial laminectomy.

b. Complications: Include, but are not limited to, nerve damage, spinal fluid leakage, infection, and hemorrhage.

c. Surgical Indications: To include all of the following:

i. Primary Radicular symptoms, with clinical evidence of radiculopathy and radiculitis on exam, (Refer to E.4. at the beginning of this section for a description of radiculopathy)

ii. Specific diagnosis of nerve root compression proven by MRI or CT myelogram, and correlated to exam findings

iii. Failure of six weeks of active therapy. In some cases, surgery may need to occur sooner due to an individual's inability to participate in active therapy.

iv. Epidural injections have not been proven to have long-term benefit; however they may be trialed prior to surgery if the patient wishes to try to avoid surgery or is unable to participate in therapy after the first two weeks.

v. The purpose of spinal injections, as well as surgery, is to facilitate active therapy by providing short-term relief through reduction of pain. Since most patients with these conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment.

vi. There is good evidence that after six weeks of active therapy, those patients with persistent radicular leg pain and an image-confirmed disc herniation have better functional outcomes with surgery than non-operated patients. This outcome is more likely to be observed within the first two to three months after surgery. However non-operative groups also improved significantly over two years (Weinstein, 2006; Chou, 2009).

d. Operative Treatment: Partial discectomy and root decompression.

e. Post-Operative An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is often recommended to be initiated three to twelve weeks post-operatively. The goals of the therapy program should include instruction in a long-term home based exercise program (refer to Therapy – Active). Medium or heavy lifting should not be begun before 10 to 12 weeks in most cases.

2. Percutaneous Discectomy

a. Description: An invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control.

b. Complications: Include, but are not limited to, injuries to the nerve or vessel, infection, hematoma, and incomplete nerve root decompression.

c. Surgical Indications: Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long-term improvement.

3. Laminotomy/Laminectomy/Foramenotomy/ Facetectomy – For central or lateral spinal stenosis

a. Description: These procedures provide access to produce neural decompression by partial or total removal of various parts of spinous elements.

b. Complications: Include, but are not limited to, nerve injury, post-surgical instability, cerebrospinal fluid (CSF) leakage, hematoma, infection, and incomplete decompression.

c. Surgical Indications: Include all of the following:

i. Radicular symptoms or symptoms of neurogenic claudication, often with clinical evidence of radiculopathy that correlates with the patient's pain and findings.

ii. Evidence of nerve root compression generally proven by MRI or CT myelogram.

iii. Failure of non-surgical care. For patients with stenosis, non-surgical active treatment should generally

consist of 6 to 12 weeks for an adequate trial. Patients with severe stenosis that correlates with symptoms often do not improve with conservative care.

iv. There is good evidence that surgical treatment leads to better symptomatic and functional outcomes however those with non-surgical treatment may also improve slightly. The non-operative improvement appears to be less likely for stenosis than for herniated discs. In the randomized spinal stenosis trial with cross over, 1/3 of those in the surgery group did not have surgery and about 40 percent of those in the non-surgical group eventually had surgery (Weinstein, 2008, Chou, 2009).

v. The purpose of spinal injections, as well as surgery, is to facilitate active therapy by providing short-term relief through reduction of pain. Since most patients with these conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment.

d. Operative Treatment: Laminotomy, laminectomy, root decompression, and excision of synovial cyst.

e. Post-Operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is often recommended to be initiated three to twelve weeks post-operatively. The goals of the therapy program should include instruction in a long-term home based exercise program (refer to Therapy – Active). Medium or heavy lifting should not be begun before 10 to 12 weeks in most cases.

4. Spinal Fusion – usually combined with decompression

a. Description: Use of bone grafts, sometimes combined with instrumentation, to produce a rigid connection between two or more adjacent vertebrae.

b. Complications: Complications include instrumentation failure, bone graft donor, site pain, superficial infection, deep wound infection, and graft extrusion. There is an increased likelihood of complications with instrumented fusion, although the majority of them are minor. There is some evidence that morbid obesity increases hospital length of stay, mortality and postoperative complications of spinal fusion surgery and results in concomitant increases in cost (Kalanithi, 2012). Fusion can accelerate adjacent level disease. In one study, more than 1/3 of patients required surgery at an adjacent level by ten years (Ghiselli, 2004). Refer to the following recombinant human bone morphogenetic protein section for complications from their use.

c. A timely decision-making process is recommended when considering patients for possible fusion. The treatment for some patients with lumbar fractures may

be immediate fusion. For chronic low back problems, fusion should not be performed within the first five months of symptoms, except for fracture, dislocation, or for some patients with functional loss due to stenosis and instability (Rihn, 2011).

d. One study of lumbar fusion outcomes in a population of workers compensation patients showed that complications occurred in 36 percent of patients with a 26 percent reoperation rate. Only 26 percent of patients returned to work while 67 percent of non-operated case returned to work however, it is not clear that severity was fully controlled for. Of the patients with lumbar fusion the following predicted non-return to work: daily morphine usage above 25MEQ 90 days post-surgery, reoperation, complications from surgery, and days off work prior to surgery (Nguyen, 2011). Another study of workers compensation patients and others on government funded programs (Social Security Disability Insurance (SSDI), Medicaid and Medicare age below 50 years) found that workers compensation (WC) patients continued to have significantly less benefit for relief of leg and back pain and lesser benefits on the Oswestry Disability Index than other patients, both controls and others on government programs (Gum, 2013). The American Pain Society Guidelines note that less than half of patients with degenerative changes treated by fusion experience no pain or only sporadic pain, only a slight restriction in function and occasional use of analgesics. Fusion outcomes are better for those with symptomatic stenosis and instability (Chou, 2009).

e. There is good evidence that decompression and fusion, with or without instrumentation, of lumbar stenosis with degenerative spondylolisthesis leads to better two year outcomes for patients whose symptoms are severe. However, patients who choose non-operative treatment can also expect their symptoms to improve with nonsurgical treatment, and non-operative treatment is acceptable if this is the patient preference (Weinstein, 2007). Physicians should consider this when advocating for surgical procedures in this population. To assure better outcomes fusions should only be performed on those who meet the indications below.

f. There is some evidence that provocative discography, facet joint blocks and temporary external transpedicular fixation do not adequately screen patients with nonspecific low back pain for fusion success. The tests tend to be sensitive but not specific (Willems, 2012).

g. In early studies of patients with spondylolisthesis undergoing decompression with or without instrumentation the relationship between a solid radiographic fusion and a good clinical outcome was not apparent (Fischgrund 1997). However, a later follow-up of the same population showed that 86 percent of the patients with a solid fusion had good to excellent clinical outcomes, compared to only 56 percent of patients who had a pseudarthrosis (Kornblum 2004). There remains uncertainty concerning the optimal imaging method to detect a pseudarthrosis, with controversy about the amount of motion on flexion-extension films which indicate that a solid fusion has been achieved, and whether the information to be gained from a thin-cut CT justifies the radiation dose associated with that form of imaging. This guideline does not make a recommendation on the clinical significance of fusion detected by any form of imaging.

h. There is some evidence that fusion is likely to have a higher beneficial effect compared to multidisciplinary rehabilitation for patients with isthmic spondylolisthesis, as differentiated from those without the condition who suffered from chronic low back pain (Wood, 2011).

i. There is good evidence that intensive exercise for approximately 25 hours per week for four weeks, combined with cognitive interventions emphasizing the benefits of maintaining usual activity, produces functional results similar to those of posterolateral fusion in patients with chronic non-radicular back pain and no stenosis or instability after one year (Brox, 2003). This population may not reflect the workers compensation population as there is frequently little access to intensive rehabilitation programs. There is some evidence that lumbar fusion produces better symptomatic and functional results in patients with chronic non-radicular pain when several months of conservative treatment have not produced a satisfactory outcome (Fritzell, 2001, Chou, 2009). Fusions associated with decompression are more likely to reduce leg pain in the presence of stenosis.

j. The effect of comorbidities on surgical outcomes should be considered and discussed with the patient before proceeding with complex spinal surgery. There is some evidence that morbid obesity increases hospital length of stay, mortality, and postoperative complications after spinal fusion surgery, with concomitant increases in hospital costs (Kalanithi, 2012). Another similar study did not find increased hospital stays but did show an increased cost and higher rates of non-routine discharges and transfusions for obese and morbidly obese patients. A third study of spinal fusion and metabolic syndrome found higher hospital charges, higher rates of non-routine discharges and increased rates of major life-threatening complications (Mementsoudis, 2012).

k. Informed decision making should be documented for all invasive procedures. This must include a thorough discussion of the pros and cons of the procedure and the possible complications as well as the natural history of the identified diagnosis.

l. The purpose of spinal injections, as well as surgery, is to facilitate active therapy by providing short-term relief through reduction of pain. Since most patients with these conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment.

m. Use of Recombinant Human Bone Morphogenetic Protein (rhBMP-2) in fusions: A member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques.

i. At the time of this guideline revision, rhBMP-2 is FDA approved for use in anterior lumbar interbody fusion (ALIF) at one level from L4-S1 in a skeletally mature patient and is used with a carrier, such as a collagen sponge or other matrix, and a cage. There is some evidence that anterior interbody cage fusion using rhBMP-2 results in shorter operative time compared with the use of iliac crest bone autograft (Ohtori, 2011). Minor pain at the iliac crest donor site may persist for 24 months or longer in approximately 30 percent of patients who undergo an autograft procedure, although local bone graft can also be used for single level fusions (Sasso, 2005). RhBMP-2 avoids

the need for harvesting iliac crest donor bone and can therefore, avoid this complication of persistent pain. Despite this, there is good evidence that rhBMP has no clinically important advantage over bone graft for anterior lumbar interbody fusion or posterior lumbar fusion (Fu, 2013).

ii. There is a potential for patients to develop sensitizing or blocking antibodies to rhBMP-2 or to the absorbable collagen sponge. The long-term effects are unknown. The rhBMP-2 used with the interbody fusion device is contraindicated for patients with a known hypersensitivity to Recombinant Human Bone Morphogenetic Protein -2, bovine type 1 collagen, or to other components of the formulation. Use of rhBMP-2 outside the anterior cage may carry a risk of swelling and ectopic bone formation, which can encroach on neurovascular structures. One study noted a higher incidence of retrograde ejaculation in ALIF cases using rhBMP-2 (Comer, 2012).

iii. One study has reported increased neurological compromise when rhBMP was used for posterior interbody fusion or transforaminal lumbar interbody fusion (Wong, 2008). Another systematic review of rhBMP for posterior interbody fusions, posterior lumbar interbody fusion and transforaminal lumbar interbody fusion, noted appreciable rates of complications including heterotopic ossification within the epidural space or neuroforamina, postoperative radiculitis and endplate osteolysis with interbody subsidence (Chrastil, 2013). At the time of this guideline revision, it is still not FDA approved for posterior interbody fusion use and considered investigational. These results should be considered prior to its use. There is insufficient information to form a recommendation with instrumentation other than the cage specifically designed for anterior procedures. If the FDA approves its use for other operative approaches, prior authorization is required. The patient must meet all indications on the device manufacturer's list and have no contraindications. The formation of exuberant or ectopic bone growth at the upper levels (L2-L4) may have a deleterious impact on certain neurovascular structures, such as the aorta and sympathetic nerve chain. There are also reports of osteoclastic activity with the use of rhBMP-2. One follow-up study noted bone resorption after transforaminal lumbar interbody fusion with rhBMP-2 at a moderate or severe level in 49 percent of patients treated with or without a cage (McClellan, 2006). This can also result in worsening back pain in the first three months after the procedure. However early osteolysis can resolve (Lewandrowski, 2007).

n. Diagnostic Indications: for spinal fusion may include the following:

i. Neural Arch Defect usually with stenosis or instability: Spondylolytic spondylolisthesis, congenital unilateral neural arch hypoplasia. It should be noted that the highest level of success for spinal fusions is when spondylolisthesis grade 2 or higher is present (Wood, 2011).

ii. Segmental Instability: Excessive motion, as in degenerative spondylolisthesis 4mm or greater, surgically induced segmental instability.

iii. Primary Mechanical Back Pain/Functional Spinal Unit Failure: Multiple pain generators objectively involving two or more of the following: internal disc disruption (poor success rate if more than one disc

involved), painful motion segment, as in isolated annular tears, disc resorption, facet syndrome, and/or ligamentous tear. Because surgical outcomes are less successful when there is neither stenosis nor instability, the requirements for pre-operative indications must be strictly adhered to for this category of patients.

iv. Revision surgery for failed previous operation(s) if significant functional gains are anticipated.

v. Other diagnoses: Infection, tumor, or deformity of the lumbosacral spine that cause intractable pain, neurological deficit, and/or functional disability.

o. Pre-operative Surgical Indications: Required pre-operative clinical surgical indications for spinal fusion include all of the following:

i. All pain generators are adequately defined and treated; and

ii. All physical medicine and manual therapy interventions are completed; and

iii. X-ray, MRI, or CT myelography demonstrate spinal stenosis with instability, or disc pathology requiring decompression that may surgically induce segmental instability, or positive CT discography; and

(a). There is good evidence that a positive discogram does not predict positive results from a fusion with the same success rate as documented spondylolisthesis (27 percent success rate compared to 72 percent success rate) (Carragee, 2006b). A similar prospective study found that a painful disc (that is, a positive discogram) is a poor independent predictor of low back pain in initially asymptomatic subjects. Psychometric profiles, work loss, medication usage were strongly predictive of subsequent low back pain. An annular tear of high intensity zone on MRI was weakly associated (Carragee, 2004). Discography should never be the sole imaging indication for surgery.

iv. Spine pathology is limited to two levels; and

v. Psychosocial evaluation has been completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention; and

vi. For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively (Andersen, 2001).

p. Operative Treatment: Operative procedures may include:

i. Intertransverse or posterior fusion often with pedicle screws;

ii. Anterior fusion (with or without rhBMP-2) – generally used for component of discogenic pain where there is no significant radicular component requiring decompression;

iii. Posterior interbody fusion – generally used for component of discogenic pain where posterior decompression for radicular symptoms is also performed; or

iv. Anterior/posterior (360°) fusion – most commonly seen in unstable or potentially unstable situations or non-union of a previous fusion. Iliac crest bone grafts do not appear to result in increased complications, reoperation or patient dissatisfaction (Radcliff, 2012).

v. Choice of instrumentation is based on the patient's anatomy, the patient's pathology, and surgeon's experience and preference. The 1009 process will not decide on specific vendors, pricing, instrumentation, or products; authorization for specific product use must come from the carrier.

q. Post-Operative An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. There is some evidence that it is appropriate to defer active rehabilitation until 12 weeks as groups beginning at six week had worse outcomes (Oestergaard, 2012). Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking), and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program that includes core stabilization, strengthening, and endurance is recommended to be initiated once the fusion is solid and without complication. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program should include instruction in a long-term home based exercise program (refer to Therapy – Active).

r. Return to Work: Barring complications, patients responding favorably to spinal fusion may be able to:

i. return to sedentary-to-light work within six to twelve weeks post-operatively;

ii. light-to-medium work within six to nine months post-operatively;

iii. medium-to-medium/heavy work within 6 to 12 months post-operatively; and

iv. heavy-to-very-heavy post-operative labor should be considered for vocational assessment as soon as reasonable restrictions can be predicted;

v. the practitioner should release the patient with specific physical restrictions and should obtain a clear job description from the employer if necessary. Once an injured worker is off work greater than six months, the functional prognosis with or without fusion becomes guarded for that individual.

5. Dynamic Neutralization System

a. A possible option to spinal fusion for patients with Grade 1 instability and symptomatic stenosis is a currently available in a posterior stabilization system device. This device attaches with pedicle screws and intends to address instability while allowing some segmental motion. It is expected to protect adjacent disc levels from the deterioration experienced with a complete fusion. It is also thought to provide a less invasive, less risky surgical

procedure for patients with degenerative disc disease and functionally impairing pain with instability and stenosis.

b. The FDA has not fully approved this system for this indication. Some case series of patients with stenosis and grade 1 instability have indicated less operating time, more rapid return to function and a slightly better outcome than those who received decompression and fusion.

c. At this time the procedure is not recommended. Further studies may provide more conclusive information. If it is being considered the patient should not have osteoporosis and must meet all of the indications for fusion at one or two levels, including prior authorization. They should also have predominant leg pain over back pain (Welch, 2007; Schwarzenbach, 2005).

6. Sacroiliac Joint Fusion

a. Description: Use of bone grafts, sometimes combined with metal devices and other instrumentation to produce a rigid connection between the sacrum and ilium.

b. Complications: Include instrumentation failure, bone graft donor site pain, in-hospital mortality, deep infection, superficial infection, and graft extrusion. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician

c. Surgical Indications: A timely decision-making process is recommended when considering patients for possible fusion. For chronic sacroiliac pain, fusion should not be considered within the first six months of symptoms, except for fracture or dislocation.

d. Diagnosis of Sacroiliac pain when considering sacroiliac fusion may include the following:

i. Traumatic severe disruption of the pelvic ring. See Chapter 23: Subchapter A. (Lower Extremities Medical Treatment Guidelines) §2309. (Specific Lower Extremity Injury Diagnosis, Testing, and Treatment) 3. (Hip and Leg) i. (Pelvic Fracture).

ii. Chronic or severe sacroiliac joint pain: SI joint pain can be confused with lumbar and hip pain. Proper diagnosis is the key to appropriate patient management.

(a). Pain patterns associated with the SI joint demonstrate variation in pain patterns, including history and symptoms of pain, provocative exam maneuvers producing pain, and patterns of relief noted after SI joint blocks. Typical pain can be in the buttocks with the pain inferior from the posterior inferior iliac spine; buttock pain extending into the posterolateral thigh; pain located within 10 cm of the posterior superior iliac spine; possible radiation into the groin or upper legs; and pain that is unilateral with absence of lumbar pain.

(b). Specific physical exam maneuvers that stress the SI joint (distraction test, compression test, thigh thrust, FABER or Patrick's test, Gaenslen's maneuver, sacral sulcus tenderness) must be performed and documented; in combination these tests are thought to be predictive of SI joint pain.

(c). Imaging of the SI joint does not typically provide valuable diagnostic information for this condition, but is used to ensure that the patient does not have alternative diagnoses that could mimic SI joint pain.

(d). The diagnosis of SI joint pain is confirmed by performing a fluoroscopy guided SI joint block with local anesthetic; an acute reduction of pain of 80 percent or more

compared to pain level immediately prior to the block must be documented.

(e). To assure that the SI joint is the primary pain generator, non-SI joint causes of pelvic or lower back pain (ankylosing spondylitis, osteoarthritis of the hip, L5/S1 spine degeneration, fracture, tumor, infection, skeletal deformity, or other pathology) must be ruled out on the basis of history, physical exam, and/or imaging.

(f). Bilateral SI joint pain can occur, and diagnosis must be made on the basis of typical history, physical examination findings, and acute pain relief with injections, as noted above.

e. ISASS guidelines recommend: appropriate patient selection for MIS SI joint fusion. According to ISASS, MIS SI joint fusion procedures have become the surgical standard of care for selected patients with chronic SI joint pain. MIS SI Joint Fusion is a surgical procedure performed only by orthopaedic or neurologic surgeons who have successfully completed a residency in that specialty, as well as at least one specialized course in the procedure. Surgeons performing MIS SI Joint Fusion should be specifically credentialed and/or privileged at least one hospital to perform the procedure. (ISASS, 2014)

f. NASS guidelines recommend: Within the limits of a weak body of evidence, the Coverage Committee recommends coverage for percutaneous SIJ fusion when the stated inclusion criteria as outlined are met. Due to the relatively weak evidence, it is particularly critical that inclusion criteria are scrutinized and patient selection is executed with vigilance. The procedure itself has proven to be relatively safe. There is a valid concern for bias in that the overwhelming majority of the data produced so far has been industry-sponsored and generally composed of case series. However there are some data on five-year outcomes that demonstrate sustained benefit that does not appear to degrade from one year to five year time-points. The committee will revisit the quality of forthcoming evidence as it is produced in re-evaluations of the indications and coverage of this procedure. (NASS, 2015)

g. Pre-operative Surgical Indications for unilateral MIS SI Joint Fusion must include all of the following.

i. Significant SI joint pain (e.g., pain rating at least five on the 0-10 numeric rating scale where 0 represents no pain and 10 represents worst imaginable pain) with significant functional limitations in activities of daily living; pain non-radiating, unilateral, caudal to the lumbar spine (L5 vertebrae), localized over the posterior SI joint, and consistent with SI joint pain;

ii. SI joint pain confirmed with at least three specific physical exam maneuvers that stress the SI joint (e.g., distraction test, compression test, thigh thrust, FABER (Patrick's test), Gaenslen's maneuver, sacral sulcus tenderness) and recreates the patient's typical pain pattern

iii. Confirmation of the SI joint as a pain generator with equal to/greater than 80 percent acute decrease in pain for the expected duration of the anesthetic used following a fluoroscopically guided diagnostic articular SI joint block into the affected SI joint on two separate occasions;

iv. Failure to respond to at least six months of intensive non-operative treatment consisting of medication optimization, activity modification, active physical therapy

and SI joint steroid injection. Failure to respond means continued pain that interferes with activities of daily living and/or results in functional disability;

v. Additional or alternative diagnoses that could be responsible for the patient's ongoing pain or disability have been ruled out (e.g., L5/S1 compression, lumbar pain with neural compression or degenerative condition, hip osteoarthritis, somatoform disorder, tumor, infection).

vi. Psychosocial evaluation has been completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention.

vii. For diagnosis and surgery of bilateral SI joint pain, all indications above must be made bilateral, and in compliance with the pre-operative indications for unilateral indications.

viii. For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. Physicians may monitor smoking cessation with laboratory tests such as nicotine levels for long-term cessation.

h. Surgical contraindications for MIS SI Joint fusion.

i. Any case that does not fulfill ALL of the above criteria;

ii. Presence of acute, traumatic instability of the SI Joint;

iii. Less than six months of pain;

iv. Failure to pursue non-operative treatment of the SI joint;

v. Pain not confirmed with diagnostic SI joint blocks;

vi. Presence of neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for their pain;

vii. Existence of other known sacroiliac pathology that could explain the patient's pain such as: Sacral dysplasia; Inflammatory sacroiliitis (e.g., ankylosing spondylitis or other HLA-associated spondyloarthropathy'; Tumor; Infection; or Crystal arthropathy;

viii. Osteomalacia or other metabolic bone disease;

ix. Chondropathy;

x. Known allergy to titanium or titanium alloys;

xi. Prominent neurologic condition that would interfere with physical therapy;

xii. Current local or systemic infection that raises the risk of surgery;

xiii. Currently pregnant or planning pregnancy in the next two years.

i. Operative Treatment. Operative procedures may include:

i. Stabilization of a traumatic severe disruption of the pelvic ring. See Chapter 23: Subchapter A. (Lower Extremities Medical Treatment Guidelines) §2309. (Specific Lower Extremity Injury Diagnosis, Testing, and Treatment) 3. (Hip and Leg) i. (Pelvic Fracture). This procedure has

limited use in minor trauma and would be considered only on an individual case-by-case basis.

ii. Traditional open sacroiliac fusion: Not recommended except as a last resort for chronic and / or severe sacroiliac joint pain. Open fusion can provide relief but recovery times are long and the complication rate is high. Open fusion is best performed on patients that are not candidates for MIS SI Joint Fusion. A multi-center, retrospective comparative cohort study of patients who underwent SI joint fusion using either an open surgical (OS) technique using a combination of screws and cages or a minimally invasive surgical (MIS) technique with a series of titanium plasma spray (TPS) coated triangular implants. Compared to OS patients, patients who underwent MIS SI joint fusion had significantly greater pain relief and more favorable perioperative surgical measures (Smith, 2013)

iii. Unilateral MIS SI Joint Fusion: Minimally Invasive (MIS) Sacroiliac Joint Fusion or percutaneous sacroiliac joint fusion is a minimally invasive approach in which instrumentation such as allograft dowels, cages or screws, with or without bone graft, are placed percutaneous in order to achieve a fusion.

iv. Published results from a prospective multicenter trial of MIS SI Joint Fusion has substantiated high rates of pain relief, improvement of functional measures, and a low rate of both revisions and serious adverse events. (Duhon, 2013) A retrospective review of MIS SI Joint Fusion with 17 patients documented the percentages of patients who achieved substantial clinical benefit were 77 percent, 82 percent, and 88 percent at the 12, 24, and 60 month time points. Fusion was noted in 87 percent of cases (Rudolf, 2014). Multiple retrospective case series studies without control groups have also been reported. (Mason, 2013) (Sachs, 2012) (Sachs, 2013) (Kim, 2013) (Khurana, 2009) (Al-Khayer 2008) (McGuire, 2012).

v. Bilateral MIS SI Joint Fusion: Is rarely indicated, and when performed, should be done serially to minimize the impact on rehabilitation (patients who undergo simultaneous bilateral SI fusion procedures may be wheelchair or bed bound for several weeks, possibly slowing recovery.

vi. It is expected that a person would not undergo more than one SI joint fusion per side per lifetime except in the rare case that a revision is needed.

j. Post-Operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. There is some evidence in lumbar fusion studies that it is appropriate to defer active rehabilitation until 12 weeks as groups beginning at six week had worse outcomes (Oestergaard, 2012). Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking), and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program that

includes core stabilization, strengthening, and endurance is recommended to be initiated once the fusion is solid and without complication. If it is performed, care should be taken not to overly mobilize the section above and below the fusion at that time. The goals of the therapy program should include instruction in a long-term home based exercise program (Refer to Active Therapy)

7. Implantable Spinal Cord Stimulator

a. Reserved for those low back pain patients with pain, radiculopathy, and failed surgery of greater than six months duration who have not responded to the standard non-operative or operative interventions previously discussed within this document. Refer to OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

8. Intradiscal Electrothermal Annuloplasty (IDEA) - more commonly called IDET, or Intradiscal Electrothermal therapy:

a. IDET is an outpatient procedure. A wire is guided into the identified painful disc using fluoroscopy. The wire is then heated at the nuclear annular junction within the disc.

b. Due to lack of evidence indicating benefit from this procedure, it is not recommended.

9. Interspinial spacers

a. Description: Multiple interspinous spacer devices (IFDs) have been utilized to treat older patients (age 50 and over) with lumbar spinal stenosis (LSS) and intermittent neurogenic claudication (INC) Interspinous process decompression theoretically relieves narrowing of the spinal canal and neural foramen in extension, thereby reducing the symptoms of INC, secondary to lumbar spinal stenosis (LSS).

b. Complications: Complications include, but are not limited to, symptomatic spinous process fractures, new radicular defects, recurrent back pain, device extrusion, device failure with need for further surgery, and bilateral foot drop.

c. Surgical indications: The device is indicated for treatment of patients 50 or older suffering from neurogenic intermittent claudication caused by lumbar spinal stenosis (with X-ray, MRI and/or CT evidence of thickened flavum, narrowed lateral recess and/or central canal narrowing).

d. There is some evidence that X-STOP spacer (a type of spacer device) is superior to continuing nonoperative treatment after six months of conservative care has not resolved neurogenic claudication (Anderson, 2006; Zucherman, 2004, 2005; Chou, 2009). However, one of the most recent studies found that within up to four postoperative years the complication rate was as high as 38 percent, with up to an 85 percent reoperation rate, and up to a 77 percent incidence of poor outcomes (Epstein, 2012). Therefore, utilization and implantation of IFD remains extremely controversial and strict adherence to the indications is recommended. Only patients who meet the following should be considered:

- i. all pain generators are adequately defined and treated; and
- ii. all physical medicine and manual therapy interventions are completed over six months; and
- iii. impaired physical function correlated with physical findings; and
- iv. CT or MRI that demonstrates stenosis; and

v. spine pathology is limited to one or two levels; and

vi. psychological evaluation has been completed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention; and

vii. it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing.

e. Additionally, the candidate should meet the following criteria:

- i. 50 years or older; and
- ii. sit for 50 minutes without pain; and
- iii. walk up to 50 feet or more; and
- iv. relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain.

f. Contraindications:

- i. anatomy that prevents implantation due to significant lumbar instability, ankylosis, acute fracture of the spinous process or pars interarticularis;
- ii. allergy to titanium or titanium alloy;
- iii. significant scoliosis;
- iv. fixed motor deficit;
- v. cauda equina syndrome;
- vi. neural compression causing neurogenic bowel or bladder dysfunction;
- vii. previous lumbar surgery;
- viii. significant peripheral neuropathy;
- ix. spondylolisthesis greater than 1.0 (on a scale from 1-4) at the affected level;
- x. sustained pathological fractures;
- xi. severe osteoporosis of the vertebrae or hips;
- xii. severe foraminal stenosis;
- xiii. obesity;
- xiv. active infection or systemic disease;
- xv. Paget's disease or metastasis to the vertebrae;
- xvi. steroid use for more than 1 month with 12 months preceding surgery;
- xvii. relative contraindication: adjacent level disease.

g. Operative Treatment: Patients are placed on a radiolucent table in the right lateral decubitus position and asked to flex their spine. After the correct operative levels are confirmed through fluoroscopy, patients receive a local anesthetic. General anesthesia is typically not required. A mid-sagittal incision of approximately 4 cm is made over the spinous process of the stenotic level(s) and the musculature is elevated to the level of the lamina and facets. Occasionally, hypertrophied facets that are blocking entry to the anterior Interspinous space can be partially trimmed to enable anterior placement of the implant. A curved dilator is then inserted into the anterior margin of the interspinous space to pierce the Interspinous ligament. A sizing distractor is then inserted to determine the appropriate implant size. The spacer is then secured to the insertion instrument and inserted into the interspinous space. The implant is placed as close to the posterior aspect of the lamina as possible. An

adjustment wing is then fastened to the implant and positioned as close to the midline as possible. The incision is then closed, and patients without significant comorbidities are typically allowed to return home on the same day as surgery.

h. **Post-Procedure Therapy:** A formal physical therapy program should be implemented post-operatively. Some patients may benefit from several occupational therapy visits. Rehabilitation may take as long as six months and include stretching during the first month, floor exercise program, and sports activities in the fifth and sixth months as tolerated. The goals of the therapy program should include instruction in a long-term home-base exercise program (refer to G.12. Therapy-Active).

i. **Return to Work:** Barring complications, the patient may be able to return to limited duty after one to two weeks. Sitting upright is limited to 30 to 45 minutes for the first two weeks. Lifting limits are 0 to 10 pounds for the first six weeks post-procedure. If successful, patients may return to medium work category (20 to 50 pounds per U.S. Department of Labor standards) at four to six months.

10. Laser Discectomy:

a. Involves the delivery of laser energy into the center of the nucleus pulposus using a fluoroscopically guided laser fiber under local anesthesia. The energy denatures protein in the nucleus, causing a structural change, which is intended to reduce intradiscal pressure. Its effectiveness has not been shown.

b. Laser discectomy is not recommended.

11. Artificial Lumbar Disc Replacement:

a. **Description.** This involves the insertion of a prosthetic device into an intervertebral space from which a degenerated disc has been removed, sparing only the peripheral annulus. The endplates are positioned under intraoperative fluoroscopic guidance for optimal placement in the sagittal and frontal planes. The prosthetic device is designed to distribute the mechanical load of the vertebrae in a physiologic manner and maintain ROM.

b. **General selection criteria** for lumbar disc replacement includes symptomatic one-level degenerative disc disease. The patient must also meet fusion surgery criteria, and if the patient is not a candidate for fusion, a disc replacement procedure should not be considered. Additionally, the patient should be able to comply with pre- and post-surgery protocol.

c. There is some evidence that disc replacement has a slight advantage over multidisciplinary intensive treatment - 60 hours over five weeks (Hellum, 2011). Multidisciplinary therapy of some type should always be trialed before surgical consideration given the inherent risks of surgery. There is strong evidence that disc replacement is not inferior to fusion at 24 months for relief of back pain, reduction of disability and provision of patient satisfaction (Jacobs, 2013). There is good evidence that the Charite disc is not inferior to allograft fusion with the BAK cage for single level disease and some evidence that the ProDisc is non-inferior to circumferential fusion with iliac crest autograft for single level disease (Van den Eerenbeemt, 2010).

d. There is some evidence that a two-level lumbar disc replacement is not inferior to circumferential fusion in

patients with 2 level degenerative disc disease 24 months after surgery (Delamarter, 2011). However, at this time the FDA has approved this procedure for only one level.

e. Long-term follow-up studies for several of the current discs is lacking. Patients who had a lumbar ProDisc-L placed had lower scores at five years than previously, although 88 percent were satisfied or somewhat satisfied and 60 percent would undergo the procedure again (Park, 2012). Seventeen-year follow up of Charite disc replacement found spontaneous ankylosis in 60 percent and reoperation in 11 percent. There was no adjacent level degeneration in the 17 percent of functional implants. Patient with ankylosis were more satisfied than those without (Putzier, 2006).

f. The ten year outcome for the Acro-flex lumbar disc replacement on a small series of patients reported a 39.3 percent rate of surgical revision most with conversion to fusion. The study also reported adjacent level disc degeneration in the majority of those with disc disease and 50 percent of those with fusion (Meir, 2013). There is good evidence from a comparison of ProDisc-L versus circumferential fusion that arthroplasty is not inferior to fusion and for preservation of motion over fusions (Zigler, 2007). There is some evidence from a five year follow up of ProDisc-L versus circumferential fusion that arthroplasty reduces the risk of adjacent disease. This study found a three times lower rate of new adjacent disc disease for disc replacement (6.7 percent versus 23.8 percent). The rate of surgery at an adjacent level did not differ significantly. Both groups improved in most scores similarly (Zigler, 2012).

g. The theoretical advantage of total disc arthroplasty is that it preserves range of motion and physiologic loading of the disc. This could be an advantage for adults who are physically active. Studies do not demonstrate a long-term advantage of measured function or pain over comparison groups undergoing fusion. The longevity of this prosthetic device has not yet been determined. Significant technical training and experience is required to perform this procedure successfully. Surgeons must be well-versed in anterior spinal techniques and should have attended appropriate training courses, or have undergone training during a fellowship. Mentoring and proctoring of procedures is highly recommended. Reasonable pre-operative evaluation may include an angiogram to identify great vessel location. The angiogram may be either with contrast or with magnetic resonance imaging. An assistant surgeon with anterior access experience is required.

h. Informed decision making should be documented for all invasive procedures. This must include a thorough discussion of the pros and cons of the procedure and the possible complications as well as the natural history of the identified diagnosis. The purpose of surgery is to facilitate active therapy by providing short-term relief through reduction of pain. Since most patients with these conditions will improve significantly over time, without invasive interventions, patients must be able to make well-informed decisions regarding their treatment.

i. Complications:

- i. nerve and vascular injury;
- ii. dural tears;
- iii. sexual dysfunction (retrograde ejaculation);
- iv. mal-positioning of the prosthesis;

- v. suboptimal positioning of the prosthetic may compromise the long-term clinical result;
- vi. Complex Regional Pain Syndrome (CRPS);
- vii. complications from abdominal surgery (e.g., hernia or adhesions);
- viii. re-operation due to complications.
- j. Surgical Indications:
 - i. symptomatic one-level degenerative disc disease established by objective testing (CT or MRI scan followed by [positive provocation discogram]);
 - ii. symptoms unrelieved after six months of active non-surgical treatment;
 - iii. all pain generators are adequately defined and treated;
 - iv. all physical medicine and manual therapy interventions are completed;
 - v. spine pathology limited to one level; and
 - vi. psychosocial evaluation with confounding issues addressed. Psychological/psychosocial measures have been shown to have predictive value for postoperative response. Certain psychological comorbidities and psychological risk factors are empirically associated with poor outcome and/or delayed recovery. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions prior to consideration of elective surgical intervention;
- k. Contraindications:
 - i. significant spinal deformity/scoliosis;
 - ii. symptomatic facet joint arthrosis – if imaging findings and physical exam of pain on extension and lateral bending are present, exploration of facet originated pain should be completed prior to disc replacement (wong, 2007);
 - iii. spinal instability at the pathologic or adjacent level requiring fusion;
 - iv. deficient posterior elements;
 - v. infection;
 - vi. any contraindications to an anterior abdominal approach (including multiple prior abdominal procedures);
 - vii. evidence of nerve root compression, depending on the device used;
 - viii. previous compression or burst fracture;
 - ix. multiple-level degenerative disc disease (DDD).
 - x. spinal canal stenosis.
 - xi. spondylolysis.
 - xii. spondylolisthesis greater than 3 mm.
 - xiii. osteopenia, osteoporosis or any metabolic bone disease.
 - xiv. chronic steroid use or use of other medication known to interfere with bone or soft tissue healing.
 - xv. allergy to device components/materials.
 - xvi. depending on the device selected, pregnancy or desire to become pregnant.
 - xvii. morbid obesity (e.g., body/mass index [BMI] of greater than 40, over 100 pounds overweight).
 - xviii. active malignancy.
 - xix. generalized chronic pain

1. Post-Operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-Operative. In all cases, communication between the physician and therapist is important to the timing of exercise progressions. Bracing may be appropriate. A formal physical therapy program should be implemented post-operatively. Post-operative active treatment will frequently require a repeat of the therapy sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated at the discretion of the surgeon. Lifting and bending are usually limited for several months at least. Sedentary duty may be able to begin within six weeks in uncomplicated cases. The goals of the therapy program should include instruction in a long-term home based exercise program (refer to Therapy – Active).

12. Kyphoplasty

a. Description: A surgical procedure for the treatment of symptomatic thoracic or lumbar vertebral compression fractures, most commonly due to osteoporosis or other metabolic bone disease, and occasionally with post-traumatic compression fractures and minor burst fractures that do not significantly compromise the posterior cortex of the vertebral body. Pain relief can be expected in approximately 90 percent of patients. There is good evidence that kyphoplasty provides rapid improvement in function in the initial months after the fracture as compared to non-operative treatment or analgesics alone (Boonen, 2011; Wardlaw, 2009). There is no clear long-term advantage. The natural history of recovery from vertebral fractures would indicate that most patients will recovery in approximately 12 weeks. There is no evidence that kyphoplasty is superior to vertebroplasty.

b. Complications: Cement leakage occurs in approximately 10 percent or less of kyphoplasties and may cause complications (McGirt, 2009). New vertebral compression fracture may occur following kyphoplasty, but their occurrence does not appear to exceed that of osteoporotic patients who did not receive treatment.

c. ...

d. Surgical Indications: There is no evidence that kyphoplasty improves long-term outcome over conservative care (Lee, 2012). Kyphoplasty is an accepted treatment during the first 12 weeks, for all the following indications:

- i. compression fracture, and
- ii. vertebral height loss between 15 percent and 85 percent, and
- iii. patients whose pain is severe while using analgesics after the first four weeks and who are unable to perform activities of daily living.

e. Contraindications:

- i. asymptomatic vertebral body compression fracture.

- ii. patient improvement with medical treatment.
- iii. the presence of neurologic compromise related to fracture;
- iv. high-velocity fractures with a significant burst component;
- v. significant posterior vertebral body wall fracture;
- vi. severe vertebral collapse (vertebra plana);
- vii. infection;
- viii. coagulopathy.

13. Vertebroplasty:

a. Description: A minimally invasive surgical procedure for the treatment of painful thoracolumbar vertebral compression fractures secondary to osteoporosis or other metabolic bone disease. Traditionally a low-viscosity acrylic bone cement, polymethylmethacrylate (PMMA), is injected with high pressure into the vertebral body under fluoroscopic guidance. Other types of bone cement such as high-viscosity PMMA, glass polymers, hydroxyapatite, and calcium phosphate have recently been made commercially available. The procedure is usually performed under intravenous sedation or light general anesthesia. A bone biopsy needle or trocar needle (11- to 13-gauge) is placed into the vertebral body and cement is injected very slowly under constant fluoroscopic guidance to minimize cement leakage. The goal of the procedure is to stabilize the spine and to relieve pain.

b. Evidence on long-term follow up for vertebroplasty is currently lacking. While the available information indicates that the majority of fractures will heal after 8 to 12 weeks of conservative treatment, a modest benefit in pain reduction was seen with vertebroplasty compared to controls at 3 and 12 months in two of the three populations studied (Blasco, 2012; Klazen, 2010), though no benefit was seen over controls in the other trial at either time period (Rousing, 2010). Given the current information, it appears that the majority of the benefit of vertebroplasty over nonoperative treatment is in the early term period. The Klazen randomized trial supported a more rapid improvement in pain and function with vertebroplasty after an average of 5.6 weeks post symptoms.

c. The procedure is not primarily intended to correct spinal deformity. Vertebral body height correction measurements are inconsistent between studies and, as such, are not comparable (Liu, 2010; Klazen, 2010; Farrokhi, 2011; Blasco, 2012). The two long-term studies examining lasting restoration of vertebral body height or kyphotic angle found conflicting results (Farrokhi, 2011; Blasco, 2012).

d. While observational and open-label studies have indicated that vertebroplasty is effective for pain relief in up to 90 percent of patients, the internal validity of these findings is problematic due to widespread lack of blinding. Two double-blind, placebo-controlled trials (Buchbinder, 2009; Kallmes, 2009) failed to show a benefit over local anesthetic administered in a "sham procedure" for either pain or quality of life. These studies have been criticized for selection bias due to the inclusion of fractures over three months old and the failure of most patients to be willing to enroll in a randomized trial.

e. There is good evidence that vertebroplasty improves pain scores more rapidly than individualized pharmacological therapy for patients with acute osteoporotic

vertebral fractures with effects detectable in the first day and persisting up to one year (Klazen, 2010). There is also good evidence that osteoporotic vertebral fractures improve equally with both vertebroplasty and with well-simulated sham vertebroplasty which includes infiltration of the periosteum with local anesthesia (Kallmes, 2009). There is good evidence that vertebroplasty does not differ from sham procedure in patients with MRI evidence of edema or fracture however many of the patients were more than six weeks from the initial symptoms and patients could have had pain for up to 12 months (Buchbinder 2009).

f. When considering vertebroplasty, the judgment of the individual treating clinician is essential in taking into consideration the potential risks of conservative management, including prolonged immobilization, muscle wasting, increased risk of pulmonary infection, and deep venous thrombosis that could lead to pulmonary embolism (Rousing, 2009).

g. Complications: Because the bone cement is of low viscosity, its injection under pressure frequently results in extravertebral extravasation of the material, with rare serious complications such as pulmonary embolism, radiculopathy, and paraplegia. Procedure-related deaths have been reported. While incidence of serious complications are rare, cement leakage alone occurs in up to 80 percent of vertebroplasties (Venmans, 2011), and the long-term implications of clinically silent cement leakages remain poorly understood. Use of high-viscosity PMMA may help minimize extravasation rates, and thus the risk of leakage-related complications (Rapan, 2010; Anselmetti, 2008).

i. New vertebral compression fractures may occur following vertebroplasty. One study showed a significant association with an increased incidence in the total number of new vertebral fractures, but when analyzed by the number of patients with new fractures the risk loses statistical significance (Blasco, 2012). Another study saw an increase but was underpowered to report significance (Rousing, 2010). Yet another study found a non-significant reduction (Klazen, 2010). Still other studies reported only clinically significant incident vertebral fractures, and they also found non-significant reductions (Buchbinder, 2009; Farrokhi, 2011).

ii. It appears that there may be a risk of new vertebral fractures adjacent to the procedure site when more than one vertebra is treated and also with uncorrected vitamin D deficiency (Martinez-Ferrer, 2013). However, when taken as a whole, occurrence of new vertebral compression fractures following vertebroplasty does not appear to exceed that of osteoporotic patients who did not undergo the procedure.

h. Indications: The available information suggests that vertebroplasty may be considered for a selected subgroup of patients with painful vertebral compression fractures if they:

- i. have been radiographically confirmed,
- ii. have been localized clinically to the level of the vertebral fracture,
- iii. are unable to perform activities of daily living,
- iv. have failed to respond to at least four weeks of conservative management,
- v. are between 4 and 12 weeks since pain onset,

- vi. sufficiently healthy to undergo surgery if necessary for decompression,
- vii. have a vertebral height loss between 15 percent and 85 percent (Klazen, 2010), and
- viii. intact posterior wall.
- i. Contraindications, any of the following:
 - i. asymptomatic vertebral body compression fracture;
 - ii. patient improvement with medical treatment;
 - iii. the presence of neurologic compromise related to the fracture;
 - iv. high velocity fractures with a significant burst component;
 - v. posterior vertebral body wall fracture;
 - vi. severe vertebral collapse (vertebra plana);
 - vii. spinal canal stenosis;
 - viii. allergy to bone cement or opacification agents;
 - ix. active or incompletely treated infection; and
 - x. uncorrectable coagulopathy.

14. Percutaneous radiofrequency disc decompression: An investigational procedure that introduces a 17 gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of the contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. There have been no randomized clinical trials of this procedure at this time.

a. Percutaneous radiofrequency disc decompression is not recommended.

15. Nucleus pulposus replacement: Involves the introduction of a prosthetic implant into the intervertebral disc, replacing the nucleus while preserving the annulus fibrosus. It is limited to investigational use in the United States at this time.

a. Nucleus pulposus replacement is not recommended.

16. Epiduroscopy and Epidural Lysis of Adhesions: Refer to Injections – Other (Including Radio Frequency).

17. Intraoperative Neurophysiologic Monitoring:

a. (IONM) is a battery of neurophysiologic tests used to assess the functional integrity of the spinal cord, nerve roots, and other peripheral nervous system structures (eg, brachial plexus) during spinal surgery. The underlying principle of IONM is to identify emerging insult to nervous system structures, pathways, and/or related vascular supply and to provide feedback regarding correlative changes in neural function before development of irreversible neural injury.

b. IONM data provide an opportunity for intervention to prevent or minimize postoperative neurologic deficit. Current multimodality monitoring techniques permit intraoperative—assessment of the functional integrity of afferent dorsal sensory spinal cord tracts, efferent ventral spinal cord motor tracts, and nerve roots. Combined use of these techniques is useful during complex spinal surgery because these monitoring modalities provide important complementary information to the surgery team. Intraoperative neurophysiologic monitoring should be used during spinal surgery when information regarding spinal cord and nerve root function is desired. The appropriate diagnostic modality for the proposed surgical intervention should be utilized at the discretion of the surgeon.

18. Non-invasive electrical bone growth stimulators may be considered:

a. As an adjunct to spinal fusion surgery for those at high risk for pseudoarthrosis, including one or more of the following fusion failure risk factors:

- i. one or more previous failed spinal fusion(s);
- ii. grade II or worse spondylolisthesis;
- iii. fusion to be performed at more than one level;
- iv. presence of other risk factors that may contribute to non-healing:
 - (a). current smoking;
 - (b). diabetes;
 - (c). renal disease
 - (d). other metabolic diseases where bone healing is likely to be compromised (e.g.: significant osteoporosis);
 - (e). active alcoholism;
 - (f). morbid obesity BMI >40.

v. As treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial x-rays over a course of three months during the latter portion of the six month period;

b. No strict criteria for device removal are suggested in the literature. Implanted devices are generally removed only when the patient complains of discomfort, when there is device malfunction, or to allow for future ability to use MRI. Removal of batteries is not recommended unless there is a device malfunction or other complication.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1676 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1151 (June 2014), LR 41:

Chapter 21. Pain Medical Treatment Guidelines

Subchapter A. Chronic Pain Disorder

§2101. Introduction

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation (OWCA) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana Workers' Compensation Act as injured workers with chronic pain. Although the primary purpose of this document is advisory and educational, these guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1681 (June 2011), amended LR 41:

§2103. General Guideline Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. ...

2. **Minimal Information for Request of Authorization.** The minimum submission by a health care provider must include a current history and physical examination. As used herein, "current" means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. **Education.** Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. **Informed Decision Making.** Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. **Treatment Parameter Duration.** Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. **Active Interventions.** Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. **Active Therapeutic Exercise Program.** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. **Positive Patient Response.** Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. **Re-Evaluation of Treatment Every Three to Four Weeks.** If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. **Surgical Interventions.** Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. Pharmacy-Louisiana Law and Regulation.: All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the

level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1682 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1155 (June 2014), LR 41:

§2105. Introduction to Chronic Pain

A. -B. ...

C. Pain can generally be classified as:

1. ...

2. Neuropathic including that originating from brain, peripheral nerves or both; and

C.3. - G.

H. The IASP offers taxonomy of pain, which underscores the wide variety of pathological conditions associated with chronic pain. This classification system may not address the psychological and psychosocial issues that occur in the perception of pain, suffering, and disability and may require referral to psychiatric or psychological clinicians. These issues should be documented with preference to the diagnostic categories of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association including the subcategories of pain disorder and any other applicable diagnostic categories (i.e., depressive, anxiety, and adjustment disorders). Pain disorder associated with general medical condition may be used for treatment; however, it may not be used to establish impairment therefore, more specific DSM coding of the condition is required when appropriate.

I. ...

J. It is recognized that some health care practitioners, by virtue of their experience, additional training, and/or accreditation by pain specialty organizations, have much greater expertise in the area of chronic pain evaluation and treatment than others. Referrals for the treatment of chronic pain should be to such recognized specialists. Chronic pain treatment plans should be monitored and coordinated by pain medicine physicians with such specialty training, and/or certification.

K. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1683 (June 2011), amended LR 41:

§2107. Definitions

A. -E. ...

F. Central Sensitization. The experience of pain evoked by the excitation of non-nociceptive neurons or of nerve fibers that normally relay non-painful sensations to the

spinal cord. This results when non-nociceptive afferent neurons act on a sensitized central nervous system (CNS). Experimental data suggest that pathways normally carrying pain signals themselves become overstimulated and/or fail to respond to inhibitory influences causing increased pain. An example is 'wind-up' which occurs when cells in the dorsal horn of the spinal cord increase their rate of action potential discharge in response to repeated stimulation by nociceptors (Woolf CJ, 2006; Zhou Y 2008).

G. -I. ...

J. Hyperpathia. A condition of altered perception such that stimuli which would normally be innocuous, if repeated or prolonged, result in severe explosive persistent pain.

K. ...

L. Hypoesthesia (Negative Sensory Phenomena). Diminished sensitivity to stimulation.

M. Malingering Intentional feigning of illness or disability in order to achieve external incentives such as recreational drugs or money.

N. -S. ...

T. Neuropathy. A disturbance of function or pathological change in a nerve: in one nerve, mononeuropathy; in several nerves, mononeuropathy multiplex; or diffuse and bilateral, polyneuropathy. Neuropathy should be associated with objective findings such as consistent sensory abnormalities, consistent motor findings (e.g. weakness, atrophy, fasciculation, muscle cramping) and/or neuropathic abnormalities on EMG/nerve conduction testing.

U. -V. ...

W. Pain Threshold. The smallest stimulus perceived by a subject as painful during laboratory testing. The term also loosely applies to the biological variation among human beings in sensing and coping with pain.

X. - Z. ...

AA. Somatic Dysfunction. Somatic dysfunction is impaired or altered function of related components of the somatic (body framework) system which includes skeletal, arthrodial, and myofascial structures.

BB. Summation. Refers to abnormally painful sensation to a repeated stimulus although the actual stimulus remains constant. The patient describes the pain as growing and growing as the same intensity stimulus continues.

CC. Sympathetically Maintained Pain (SMP). A pain that is maintained by sympathetic pathways and intensified by circulating catecholamines.

DD. Tender Points. Tenderness on palpation at a tendon insertion, muscle belly or over bone. Palpation should be done with the thumb or forefinger, applying pressure approximately equal to a force of four kilograms (blanching of the entire nail bed).

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1684 (June 2011), amended LR 41:

§2109. Initial Evaluation and Diagnostic Procedures

A. ...

1. History and Physical Examination (Hx and PE). Generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other

diagnostic procedures are not complementing each other, the objective clinical findings should have preference. The medical records should reasonably document the following:

a. Medical History. As in other fields of medicine, a thorough patient history is an important part of the evaluation of chronic pain. In taking such a history, factors influencing a patient's current status can be made clear and taken into account when planning diagnostic evaluation and treatment. One efficient manner in which to obtain historical information is by using a questionnaire. The questionnaire may be sent to the patient prior to the initial visit or administered at the time of the office visit. History should ascertain the following elements.

i. General Information – General items requested are name, sex, age, birth date, etc;

ii. Level of Education – The level of patients' education may influence response to treatment;

iii. Work History/Occupation – To include both impact of injury on job duties and impact on ability to perform job duties, work history, job description, mechanical requirements of the job, duration of employment, and job satisfaction;

iv. Current employment status;

v. Marital status;

vi. Family Environment – Is the patient living in a nuclear family or with friends? Is there or were there, any family members with chronic illness or pain problems? Responses to such questions reveal the nature of the support system or the possibility of conditioning toward chronicity;

vii. Ethnic Origin – Ethnicity of the patient, including any existing language barriers, may influence the patient's perception of and response to pain. Literature indicates that providers may under-treat patients of certain ethnic backgrounds due to underestimation of their pain (Todd, 2000);

viii. Belief System – Patients should be asked about their value systems, including spiritual and cultural beliefs, in order to determine how these may influence the patient's and family's response to illness and treatment recommendations;

ix. Activities of Daily Living – Pain has a multidimensional effect on the patient that is reflected in changes in usual daily vocational, social, recreational, and sexual activities;

x. Past and present psychological problems;

xi. History of abuse – Physical, emotional, sexual;

xii. History of disability in the family;

xiii. Sleep disturbances;

xiv. Work injury: How did this injury occur; was the problem initiated by a work-related injury or exposure?

b. Pain History: Characterization of the patient's pain and of the patient's response to pain is one of the key elements in treatment.

i. Site of Pain – Localization and distribution of the pain help determine the type of pain the patient has (i.e., central versus peripheral);

ii. Pain diagram drawings to document the distribution of pain;

iii. Visual Analog Scale (VAS). Including a discussion of the range of pain during the day and how activities, use of modalities, and other actions affect the intensity of pain;

iv. Duration;
v. Place of onset. Circumstances during which the pain began (e.g. an accident, an illness, a stressful incident or spontaneous onset);

vi. Pain Characteristics – Such as burning, shooting, stabbing, and aching. Time of pain occurrence, as well as intensity, quality, and radiation, give clues to the diagnosis and potential treatment. Quality of pain can be helpful in identifying neuropathic pain which is normally present most of the day, at night and is described as burning;

vii. List of activities which aggravate or exacerbate, ameliorate, or have no effect on the level of pain;

viii. Associated Symptoms – Does the patient have numbness or paresthesia, dysesthesia, weakness, bowel or bladder dysfunction, decreased temperature, increased sweating, cyanosis or edema? Is there local tenderness, allodynia, hyperesthesia, or hyperalgesia?

c. Medical Management History.

i. Diagnostic Tests – All previous radiological and laboratory investigations should be reviewed;

ii. Prior Treatment – Chronological review of medical records including previous medical evaluations and response to treatment interventions. In other words, what has been tried and which treatments have helped?;

iii. Prior Surgery – If the patient has had prior surgery specifically for the pain, he/she may be less likely to have a positive outcome;

iv. Medications – History of and current use of medications, including over the counter and herbal/dietary supplements to determine drug usage (or abuse) interactions and efficacy of treatment. Drug allergies and other side effects experienced with previous or current medication therapy and adherence to currently prescribed medications should be documented. Ideally, this includes dosing schedules as reported by the patient or patient representative. Information should be checked against the Louisiana Prescription Drug Monitoring Program (PDMP), offered by the Louisiana Board of Pharmacy.

v. Review of Systems Check List – Determine if there is any interplay between the pain complaint and other medical conditions;

vi. Psychosocial Functioning – Determine if any of the following are present: current symptoms of depression or anxiety; evidence of stressors in the workplace or at home; and past history of psychological problems. Other confounding psychosocial issues may be present, including the presence of psychiatric disease. Due to the high incidence of co-morbid problems in populations that develop chronic pain, it is recommended that patients diagnosed with chronic pain should be referred for a full psychosocial evaluation.

vii. Pre-existing Conditions – Treatment of these conditions is appropriate when the pre-existing condition affects recovery from chronic pain.

viii. Family history pertaining to similar disorders.

d. Substance Use/Abuse:

i. Alcohol use;

ii. Smoking History and use of nicotine replacements;

iii. History of current and prior prescription and street drug use or abuse;

iv. The use of caffeine or caffeine-containing beverages;

v. Substance abuse information may be only fully obtainable from multiple sources over time. Patient self reports may be unreliable. Patient self reports should always be checked against medical records.

e. Other Factors Affecting Treatment Outcome:

i. Compensation/Disability/Litigation;

ii. Treatment Expectations – What does the patient expect from treatment: complete relief of pain or reduction to a more tolerable level?

f. Physical Examination:

i. Neurologic Evaluation – Includes cranial nerves survey, muscle tone and strength, atrophy, detailed sensory examination (see ii-below), motor evaluation (station, gait, coordination) reflexes (normal tendon reflexes and presence or absence of abnormal reflexes such as frontal lobe release signs or upper motor neuron signs, cerebellar testing and provocative neurological maneuvers.

ii. Sensory Evaluation – A detailed sensory examination is crucial in evaluating a patient with chronic pain complaints. Quantitative sensory testing, such as Semmes-Weinstein, may be useful tools in determining sensory abnormalities. The examination should determine if the following sensory signs are present and consistent on repeated examination.

(a) - (i) ...

iii. Musculoskeletal Evaluation – Range-of-motion, segmental mobility, musculoskeletal provocative maneuvers, palpation, observation, and functional activities. All joints, muscles, ligaments, and tendons should be examined for asymmetry, swelling, laxity, and tenderness. A portion of the musculoskeletal evaluation is the myofascial examination. The myofascial examination includes palpating soft tissues for evidence of tightness and trigger points.

iv. Evaluation of non-physiologic findings:

(a). Waddell's nonorganic findings, If applicable, Waddell Signs, which include five categories of clinical signs tenderness- superficial and non-anatomic, pain with simulation: axial loading and rotation, regional findings: sensory and motor inconsistent with nerve root patterns distraction/inconsistency in straight leg raising findings, and over-reaction to physical examination maneuvers. Significance may be attached to positive findings in three out of five of these categories, but not to isolated findings. Waddell advocates considering Waddell's signs prior to recommending a surgical procedure. These signs should be measured routinely to identify patients requiring further assessment (i.e., biopsychosocial) prior to undergoing back surgery.

(b) It is generally agreed that Waddell signs are associated with decreased functional performance and greater subjective pain levels, though they provide no information on the etiology of pain. Waddell Signs cannot be used to predict or diagnose malingering. Their presence of three out of five signs may most appropriately be viewed as a screening test, alerting clinicians to those patients who require a more comprehensive approach to their assessment and care plan. Therefore, for chronic back pain, a psychosocial evaluation should be part of the total

evaluation of the patient. Refer to Personality/Psychological/Psychosocial Evaluation.

(c). Variability on formal exam including variable sensory exam, inconsistent tenderness, and/or swelling secondary to extrinsic sources.

(d). Inconsistencies between formal exam and observed abilities of range-of-motion, motor strength, gait and cognitive/emotional state should be noted in the assessment.

2. Psychosocial/ Psychological Evaluation

a. These are generally accepted, and well-established, and widely used diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation not only with selected use in acute pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury or work related.

b. Psychological/ psychosocial and measures have been shown to have predictive value for postoperative response outcome, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological evaluation should identify patients who are at increased risk for poor response to medical or surgical treatment due to the presence of psychosocial risk factors, including somatization, depression, a poor relationship with the employer and childhood psychological trauma. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery. In addition, psychological testing should also include well validated measures of co-morbidities (e.g., depression, PTSD, etc.) Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results.

c. Psychosocial evaluations should determine if further psychosocial or behavioral interventions are indicated for patients diagnosed with chronic pain. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in his or her social environment, thus allowing for more effective rehabilitation. Psychosocial assessment requires consideration of variations in pain experience and expression resulting from affective, cognitive, motivational and coping processes, and other influences such as gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

d. While there is some agreement about which psychological factors need to be assessed in patients with chronic pain, a comprehensive psychological evaluation

should attempt to identify both primary psychiatric risk factors (e.g. psychosis, active suicidality), as well as secondary risk factors or (e.g. moderate depression, job dissatisfaction) (Bruns D and Disorbio J 2009). Significant personality disorders must be taken into account when considering a patient for spinal cord stimulation and other major procedures. Psychometric Testing is a valuable component of a consultation to assist the physician in making a more effective treatment plan. There is good evidence that psychometric testing can have significant ability to predict medical treatment outcome (Sinikallio S, Aalto, T, Airaksinen, O, 2009; Sinikallio S, Aalto, T, Airaksinen, O, Lehto, SM, 2010; Block A 2001). For example, one study found that psychometric testing exceeded the ability of discography to predict disability in patients with low back pain (Carragee, 2005). Pre-procedure psychiatric/psychological evaluation must be done prior to diagnostic confirmatory testing for the procedure. Examples include discography for fusion, spinal cord stimulation, or intrathecal drug delivery systems and should not be done by a psychologist employed by the physician planning to perform the procedure.

e. In many instances, psychological testing has validity comparable to that of commonly used medical tests; for example, the correlation between high trait anger and blood pressure is equal to the correlation between reduced blood flow and the failure of a synthetic hemodialysis graft (Meyer G 2001). Thus, psychometric testing may be of comparable validity to medical tests and may provide unique and useful diagnostic information (Meyer G 2001).

f. All patients who are diagnosed as having chronic pain should be referred for a psychosocial evaluation, as well as concomitant interdisciplinary rehabilitation treatment. This referral should be performed in a way so as to not imply that the patient's claims are invalid, or that the patient is malingering or mentally ill. Even in cases where no diagnosable mental condition is present, these evaluations can identify social, cultural, coping and other variables that may be influencing the patient's recovery process and may be amenable to various treatments including behavioral therapy. As pain is understood to be a biopsychosocial phenomenon, these evaluations should be regarded as an integral part of the assessment of chronic pain conditions.

g. Psychosocial Evaluation Required for Chronic Pain

i. Unless objective medical findings explain symptom persistence, any patient who has not returned to work by six months will be required to undergo a full Psychosocial Evaluation by a Psychiatrist or licensed Psychologist. The Psychosocial Evaluation will consist of two components:

(a). Up to 90 minutes of clinical interview, and

(b). Up to an additional seven hours of psychological testing which will include the following standardized tests to evaluate for underlying psychological co-morbidities (for example, depression), somatoform disorders, and motivational factors. It is recognized that some patients with pain will take longer to complete testing due to pain, fatigue or other symptoms...additional time to complete what is normally seven hours of testing may be required because of this.

(i). A comprehensive assessment of psychopathology (such as the current edition MMPI or the PAI).

(ii). Test(s) of attitudes and/or beliefs regarding pain.

(iii). Pain coping strategies.

(iv). Assessment regarding return to work.

ii. The formal psychological evaluation should address whether the patient has any psychological factors which might alter symptom reports in a way that could impact assessment or adversely affect any future treatment, including rhizotomy, discography or surgery.

h. Qualifications:

i. A licensed Psychologist or a physician with Psychiatric MD/DO credentials may perform comprehensive evaluations. It is preferable that these professionals have experience in diagnosing and treating chronic pain disorders in injured workers.

ii. Psychometric tests should be administered by licensed Psychologists or health professionals working under the supervision of a licensed Psychologist. Physicians with appropriate training may also administer such testing, but interpretation of the tests should be done by properly credentialed mental health professionals.

i. Specific Aspects of Psychosocial Evaluation: All chronic pain patients should have a clinical evaluation that addresses the following areas:

i. History of Injury. The history of the injury should be reported in the patient's words or using similar terminology. Caution must be exercised when using translators.

(a). Nature of injury;

(b). Psychosocial circumstances of the injury;

(c). Current symptomatic complaints;

(d). Extent of medical corroboration;

(e). Treatment received and results;

(f). Compliance with treatment;

(g). Coping strategies used, including perceived locus of control, catastrophizing, and risk aversion;

(h). Perception of medical system and employer;

(i). History of response to prescription medications.

ii. Health History

(a). Nature of injury;

(b). Medical history;

(c). Psychiatric history;

(d). History of alcohol or substance abuse;

(e). Activities of daily living;

(f). Previous injuries, including disability, impairment, and compensation.

iii. Psychosocial History

(a). Childhood history, including abuse/neglect;

(b). Educational history;

(c). Family history, including disability;

(d). Marital history and other significant adulthood activities and events;

(e). Legal history, including criminal and civil litigation;

(f). Employment history;

(g). Military duty- because post-traumatic stress disorder (PTSD) might be an unacceptable condition for many military personnel to acknowledge, it may be prudent

to screen initially for signs of depression or anxiety – both of which may be present in PTSD;

(h). Signs of pre-injury psychological dysfunction;

(i). Current and past interpersonal relations, support, living situation;

(j). Financial history.

iv. Mental status exam including cognition, affect, mood, orientation, thinking, and perception. May include mini mental status exam or frontal assessment battery if appropriate.

v. Assessment of any danger posed to self or others.

vi. Psychological test results, if performed.

vii. Current psychological diagnosis

viii. Pre-existing psychiatric conditions. Treatment of these conditions is appropriate when the pre-existing condition affects recovery from chronic pain.

ix. Causality (to address medically probable cause and effect, distinguishing pre-existing psychological symptoms, traits and vulnerabilities from current symptoms).

x. Treatment recommendations with respect to specific goals, frequency, timeframes, and expected outcomes.

j. Tests of Psychological Functioning:

Psychometric testing is a valuable component of a consultation to assist the physician in making a more effective treatment plan. Psychometric testing is useful in the assessment of mental conditions, pain conditions, cognitive functioning, treatment planning, vocational planning, and evaluation of treatment effectiveness. While there is no general agreement as to which psychometric tests should be specifically recommended for psychological evaluations of chronic pain conditions, standardized tests are preferred over those which are not for assessing diagnosis. In contrast, non-standardized tests can be useful for "ipsative" outcome assessment, where a test is administered more than once, and a patient's current reports are compared with his or her own reports in the past. It is appropriate for the mental health provider to use their discretion and administer selective psychometric tests within their expertise and within standards of care in the community. Use of screening psychometrics by non-mental health providers is encouraged but mental health provider consultation should always be utilized for chronic pain patients in which invasive palliative pain procedures or chronic opiate treatment is being contemplated. Some of these tests are available in Spanish and other languages, and many are written at a sixth grade reading level. Examples of frequently used psychometric tests performed include, but not limited to the following:

i. Psychological Inventories for Medical Patients:

(a). Battery for Health Improvement, Second Edition (BHI-2). What it measures – Depression, anxiety and hostility; violent and suicidal ideation; borderline, dependency, chronic maladjustment, substance abuse, conflicts with work, family and physician, pain preoccupation, somatization, perception of functioning and others. Benefits – When used as a part of a comprehensive evaluation, can contribute substantially to the understanding of psychosocial factors underlying pain reports, perceived disability and somatic preoccupation; as well as to design

interventions. Serial administrations can track changes in a broad range of variables during the course of treatment, and assess outcome. Characteristics – Standardized test normalized on patients with chronic pain or injury and on community members, with reference groups for six other subcategories of injured patients.

(b). Millon Behavioral Medical Diagnostic (MBMD): What it measures – Updated version of the Millon Behavioral Health Inventory (MBHI). Provides information on coping styles (introverted, inhibited, dejected, cooperative, sociable, etc.), health habits (smoking, drinking, eating, etc.), psychiatric indications (anxiety, depression, etc.), stress moderators (illness apprehension vs. illness tolerance, etc.), treatment prognostics (interventional fragility vs. interventional resilience, medication abuse vs. medication competence, etc.) and other factors. Benefits – When used as a part of a comprehensive evaluation, can contribute substantially to the understanding of psychosocial factors affecting medical patients. Understanding risk factors and patient personality type can help to optimize treatment protocols for a particular patient. Characteristics – Standardized test normalized on medical patients with various diseases, on obesity, and on chronic pain groups.

ii. Psychological Inventories: These tests are designed for detecting various psychiatric syndromes, but in general are more prone to false positive findings when administered to medical patients.

(a). Millon Clinical Multiaxial Inventory, Third Edition (MCMI-III). What it measures – Has scales based on DSM diagnostic criteria for affective, personality and psychotic disorders and somatization. Benefits – When used as a part of a comprehensive evaluation, can screen for a broad range of DSM diagnoses. Characteristics – Standardized test normalized on psychiatric patients.

(b). Minnesota Multiphasic Personality Inventory®, Second Edition (MMPI-2®). What it measures – Original scale constructs, such as hysteria and psychasthenia are archaic but continue to be useful. Newer content scales include depression, anxiety, health concerns, bizarre mentation, social discomfort, low self-esteem, and almost 100 others. Benefits – When used as a part of a comprehensive evaluation, measure a number of factors that have been associated with poor treatment outcome. Characteristics – Standardized test normalized on community members

(c). Minnesota Multiphasic Personality Inventory®, Second Edition Revised Form (MMPI-2®). What it measures – 50 scales assess a wide range of psychiatric disorders and personality traits, plus eight validity scales, critical items. Benefits – new version of MMPI-2 has undergone extensive revision to correct perceived MMPI-2 deficiencies. Has advantages over the original MMPI-2 in psychiatric assessment, but may be less capable when assessing patients with chronic pain. Characteristics – Standardized test normalized on community members, with multiple other reference groups.

(d). Personality Assessment Inventory (PAI). What it measures – A measure of general psychopathology that assesses depression, anxiety, somatic complaints, stress, alcohol and drug use reports, mania, paranoia, schizophrenia, borderline, antisocial, and suicidal ideation and more than 30 others. Benefits – When used as a part of a

comprehensive evaluation, can contribute substantially to the identification of a wide variety of risk factors that could potentially affect the medical patient. Characteristics – Standardized test normalized on community members.

iii. ...

(a). Brief Battery for Health Improvement, Second Edition (BBHI-2). What it measures – Depression, anxiety, somatization, pain, function, and defensiveness. Benefits – Can identify patients needing treatment for depression and anxiety, and identify patients prone to somatization, pain magnification and self-perception of disability. Can compare the level of factors above to other pain patients and community members. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome. Characteristics – Standardized test normalized on patients with chronic pain or injury and on community members, with reference groups for six subcategories of injured patients.

(b). Pain Patient Profile (P3®). What it measures – Assesses depression, anxiety, and somatization. Benefits – Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety and somatization to other pain patients and community members. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome. Characteristics – Standardized test normalized on patients with chronic pain, and on community members.

(c). Multidimensional Pain Inventory (MPI). What it measures – Interference, support, pain severity, life-control, affective distress, response of significant other to pain, and self-perception of disability at home and work, and in social and other activities of daily living. Benefits – Can identify patients with high levels of disability perceptions, affective distress, or those prone to pain magnification. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome. Characteristics – Partially standardized test, initially developed primarily with male military personnel, and later normalized on patients with chronic pain in the United States and Sweden.

(d). SF-36®. What it measures – A survey of general health well-being and functional states. Benefits – Assesses a broad spectrum of patient disability reports. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome. Characteristics – Non-standardized test without norms.

(e). Sickness Impact Profile® (SIP). What it measures – Perceived disability in the areas of sleep, eating, home management, recreation, mobility, body care, social interaction, emotional behavior, and communication. Benefits – Assesses a broad spectrum of patient disability reports. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome. Characteristics – Non-standardized test without norms.

(f). McGill Pain Questionnaire (MPQ). What it measures – Cognitive, emotional and sensory aspects of pain. Benefits – Can identify patients prone to pain magnification. Repeated administrations can track progress

in treatment for pain. Characteristics – Non-standardized test without norms.

(g). McGill Pain Questionnaire – Short Form (MPQ-SF). What it measures – Emotional and sensory aspects of pain. Benefits – Can identify patients prone to pain magnification. Repeated administrations can track progress in treatment for pain. Characteristics – Non-standardized test without norms.

(h). Oswestry Disability Questionnaire (ODQ). What it measures – Disability secondary to low back pain. Benefits – Can measure patients' self-perceptions of disability. Serial administrations could be used to track changes in self-perceptions of functional ability during the course of treatment, and assess outcome. Characteristics – Non-standardized test without norms.

(i). Visual Analog Scales (VAS). What it measures – Graphical measure of patient's pain report, where the patient makes a mark on a line to represent pain level. Benefits – Quantifies the patients' pain report, most commonly using a 10 centimeter horizontal line. Serial administrations could be used to track changes in pain reports during the course of treatment and assess outcome. Characteristics – Non-standardized test without norms. Some patients may have difficulty with this conceptual test format, depending on perceptual, visuomotor, cultural orientation or other factors.

(j). Numerical Rating Scales (NRS). What it measures – Numerical report of patients' pain. Benefits – Quantifies the patients' pain report, typically on a 0-10 scale. Serial administrations could be used to track changes in pain reports during the course of treatment and assess outcome. Characteristics – Recommended by JCAHO. Non-standardized test without norms. May be more easily understood than the VAS.

iv. ...

(a). Brief Symptom Inventory (BSI®). What it measures: Somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoia, psychoticism, and interpersonal sensitivity. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety, and somatization to community members. Serial administrations could be used to track changes in measured variables during the course of treatment, and assess outcome. Characteristics – standardized test normalized on community members.

(b). Brief Symptom Inventory – 18 (BSI-18®). What it Measures: Depression, anxiety, somatization. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety, and somatization to community members. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome. Characteristics – standardized test normalized on patients with chronic pain associated with cancer.

(c). Symptom Check List 90 (SCL 90). What it measures: Somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoia, psychoticism, and interpersonal sensitivity. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the

level of depression, anxiety and somatization to community members. Serial administrations could be used to track changes in measured variables during the course of treatment, and assess outcome. Characteristics – standardized test normalized on community members.

v. Brief Specialized Psychiatric Screening Measures

(a). Beck Depression Inventory® (BDI). What it measures: Depression. Benefits: Can identify patients needing referral for further assessment and treatment for depression and anxiety, as well as identify patients prone to somatization. Repeated administrations can track progress in treatment for depression, anxiety, and somatic preoccupation. Requires a professional evaluation to verify diagnosis. Characteristics – standardized test without norms, uses cutoff scores.

(b). Post Traumatic Stress Diagnostic Scale (PDS®). What it Measures: Post Traumatic Stress Disorder (PTSD). Benefits: Helps confirm suspected PTSD diagnosis. Repeated administrations can track treatment progress of PTSD patients. Characteristics – standardized test normalized on community members.

(c). Center of Epidemiologic Studies – Depression Questionnaire. What it measures: Depression. Benefits: Brief self-administered screening test. Requires a professional evaluation to verify diagnosis. Characteristics – nonstandardized test without norms.

(d). Brief Patient Health Questionnaire from PRIME - MD® What it measures: Depression, panic disorder. Benefits: Brief self-administered screening test. Requires a professional evaluation to verify diagnosis. Characteristics – nonstandardized test without norms, keyed to diagnostic criteria, uses cutoff scores.

(e). Zung Questionnaire. What it measures: Depression. Benefits: Brief self-administered screening test. Requires a professional evaluation to verify diagnosis. Characteristics – Non-standardized test without norms.

3. Diagnostic Testing. Imaging of the spine and/or extremities is a generally accepted, well-established, and widely used diagnostic procedure when specific indications, based on history and physical examination, are present. Physicians should refer to specific acute care OWCA guidelines for detailed information about specific testing procedures. Tests should be performed to rule in or out specific diagnoses.

a. Radiographic Imaging, MRI, CT, bone scan, radiography, SPECT, and other special imaging studies may provide useful information for many musculoskeletal disorders causing chronic pain. Single Photon Emission Computerized Tomography (SPECT): A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans & CT Scans in looking for facet joint pathology. Most imaging is likely to demonstrate aging changes which are usually not pathologic. Refer to specific guidelines for details. Patients should be informed before the test is performed the purpose of the exam, e.g. to rule out unsuspected cancer, and the likelihood that non pathologic aging changes will be found.

b. Electrodiagnostic studies may be useful in the evaluation of patients with suspected myopathic or neuropathic disease and may include Nerve Conduction Studies (NCS), Standard Needle Electromyography, or

Somatosensory Evoked Potential (SSEP). The evaluation of electrical studies is complex and should be performed by specialists who are well trained in the use of this diagnostic procedure.

c. Special testing procedures may be considered when attempting to confirm the current diagnosis or reveal alternative diagnosis. In doing so, other special tests may be performed at the discretion of the physician.

d. Testing for Complex Regional Pain Syndrome (CRPS-I) or Sympathetically Maintained Pain (SMP) is described in the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

4. Laboratory Testing. Generally accepted, well-established, and widely used procedures and can provide useful diagnostic and monitoring information. They may be used when there is suspicion of systemic illness, infection, neoplasia, underlying rheumatologic disorder or connective tissue disorder, or based on history and/or physical examination. Tests include, but are not limited to the following:

a. Complete Blood Count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;

b. Erythrocyte sedimentation rate, rheumatoid factor, Antinuclear Antigen (ANA), Human Leukocyte Antigen (HLA), and C-reactive protein can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder;

c. Thyroid, glucose and other tests to detect endocrine disorders (e.g. catecholamines, free and total testosterone levels, both of which may be deficient in chronic pain patients secondary to prolonged stress and/or chronic use of opioid analgesics);

d. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease;

e. Urinalysis can detect bacteria (usually with culture and sensitivity), calcium, phosphorus, hydroxyproline, or hematuria;

f. Liver and kidney function may be performed for baseline testing and monitoring of medications; and,

g. Toxicology screen. Serum and/or urine may be performed as appropriate. A blood alcohol level may also be appropriate if alcohol abuse is suspected.

5. Injections - Diagnostic

a. Diagnostic Spinal Injections

i. Description. Generally accepted, well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms.

(a). Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be

primary pain generators. Patients should not receive all of the diagnostic blocks listed merely in an attempt to identify 100 percent of the pain generators. The interpretation of the test results are primarily based on functional change, symptom report, and pain response (via a recognized pain scale before, and at an appropriate time after the injection). The diagnostic significance of the test result should be evaluated in conjunction with clinical information and the results of other diagnostic procedures. Injections with local anesthetics of differing duration may be used to support a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose cervical conditions. Refer to Therapeutic Procedures, Non-Operative, Injections – Therapeutic, for information on specific injections.

(b). It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure is evident to other reviewers. This entails, at a minimum, documentation of patient response immediately following the procedure including details of any symptoms with a response and the degree of response. Additionally, a log must be recorded as part of the medical record which documents response, if any, on an hourly basis for, at a minimum, the expected duration of the local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., low back, neck, leg, or arm pain). The physician must identify the local anesthetic used and the expected duration of response for diagnostic purposes.

(c). Multiple injections provided at the same session without staging may seriously dilute the diagnostic value of these procedures. Physicians must carefully weigh the diagnostic value of the procedure against the possible therapeutic value.

ii. Special Requirements for Diagnostic Injections - Since multi-planar, fluoroscopy during most procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement for all spinal procedures. The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or psychiatry. The physician who performs spinal injections for low back pain should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. The physician who performs spinal injections for cervical pain should have completed fellowship training in pain medicine with interventional training, or its equivalent. Physicians performing spinal injections for low back and cervical pain should obtain fluoroscopy training and must also have the appropriate training in radiation safety, usually overseen by a radiation safety officer.

iii. ...

iv. Contraindications. Absolute contraindications to diagnostic injections include: bacterial infection, systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy. Relative contraindications of diagnostic injections may include, allergy to contrast or shellfish, poorly controlled Diabetes Mellitus or and hypertension. Anti-platelet therapy and anti-coagulations should be addressed individually by a

knowledgeable specialist. It is recommended to refer to American Society of Regional Anesthesia for anticoagulation guidelines. Drugs affecting coagulation such as aspirin, NSAIDs and other anti-platelet or anti-coagulants require restriction from use. Decisions regarding the number of restricted days should be made in consultation with the prescribing physician and other knowledgeable experts.

v. Specific Diagnostic Injections — In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to Therapeutic Injections for information on other specific therapeutic injections. The following injections are used primarily for diagnosis:

(a). Medial Branch Blocks: (Refer to Cervical Spine and Low Back Pain Medical Treatment Guidelines.)

(b). Transforaminal Injections: (Refer to Cervical Spine and Low Back Pain Medical Treatment Guidelines.)

(c). Zygapophyseal (Facet) Blocks: (Refer to Cervical Spine and Low Back Pain Medical Treatment Guidelines.)

(d). Atlanto-Axial and Atlanto-Occipital Injections: (Refer to Cervical Spine Medical Treatment Guidelines.)

(e). Sacroiliac Joint Injection: (Refer to Low Back Pain Medical Treatment Guidelines.)

b. ...

i. Description—Generally accepted, well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms.

ii. ...

iii. Special Requirements for Diagnostic Injections—Since fluoroscopic, arthrographic and/or CT guidance during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. The subspecialty disciplines of the physicians may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The physician should have experience in ongoing injection training workshops provided by organizations such as the International Spine Intervention Society (ISIS). In addition, physicians should obtain fluoroscopy training and must have the appropriate training in radiation safety, usually overseen by a radiation safety officer.

iv. Complications - General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningial abscess. Severe complications of cervical injections are remote but can include spinal cord damage, quadriplegia, and/or death.

v. Contraindications - Absolute contraindications of diagnostic injections include: (a) bacterial infection – systemic or localized to region of injection, (b) bleeding diatheses, (c) hematological conditions, and (d) possible pregnancy.

vi. Relative Contraindications - Relative contraindications of these injections may include: (a) allergy to contrast or shellfish, (b) poorly controlled diabetes mellitus and/or hypertension. Drugs affecting coagulation, such as aspirin, NSAIDs and other anti-platelets or anti-coagulants require restriction from use. Decisions regarding the number of restricted days should be made in consultation with the prescribing physician and other knowledgeable experts.

vii. Specific Diagnostic Injections — In general, relief should last for at least the duration of the local anesthetic used and give significant relief of pain. Refer to Therapeutic Injections for information on other specific therapeutic injections. The following injections are used primarily for diagnosis:

(a). ...

(b). Peripheral Nerve Blocks: are diagnostic injections that may be used for specific nerve injury or entrapment syndromes. Refer to Injections – Therapeutic for detailed information about their use. Not all peripheral nerve blocks require fluoroscopy. On occasion they are used for treatment in chronic pain or CRPS. Repeat injection for treatment should be based on functional changes. These injections are usually limited to three injections per site per year.

6. Special Tests: are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and/or physical work demand classifications and tolerance. The procedures in this subsection are listed in alphabetical order.

a. Computer Enhanced Evaluations: may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range-of-motion, endurance, or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment and demonstrated motivation. These evaluations should not be used alone to determine return to work restrictions.

i. ...

b. Functional Capacity Evaluation (FCE): is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return-to-work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability and financial status, as well as psychosocial aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; and non-material and material handling activities. Standardized national guidelines (such as National Institute for Occupational Safety and Health (NIOSH)) should be used as the basis for FCE recommendations.

i. When an FCE is being used to determine return to a specific jobsite, the provider is responsible for fully understanding the job duties. A jobsite evaluation is frequently necessary. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering. Full FCEs are rarely necessary. In many cases, a work tolerance screening will identify the ability to perform the necessary job tasks.

ii. Frequency: Can be used: 1) initially to determine baseline status; and 2) for case closure when patient is unable to return to the pre-injury position and further information is desired to determine permanent work restrictions. Prior authorization is required for FCEs performed during treatment.

c. Jobsite Evaluation and Alterations: is a comprehensive analysis of the physical, mental, and sensory components of a specific job. The goal of the Job Site evaluation is to identify any job modification needed to ensure the safety of the employee upon return to work. These components may include, but are not limited to postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; environmental requirements of a job; repetitiveness; and essential functions of a job; and ergonomic set up. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

i. Jobsite evaluation and alteration should include input from a health care professional with experience in ergonomics or a certified ergonomist; the employee, and the employer. The employee must be observed performing all job functions in order for the jobsite evaluation to be a valid representation of a typical workday. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work. Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following:

(a). To determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

(b). To make recommendations for, and to assess the potential for ergonomic changes;

(c). To provide a detailed description of the physical and cognitive job requirements;

(d). To assist the patient in their return to work by educating them on how they may be able to do their job more safely in a bio-mechanically appropriate manner;

(e). To give detailed work/activity restrictions.

ii. Frequency: One time with additional visits as needed for follow-up per jobsite.

d. Vocational Assessment: Once an authorized practitioner has reasonably determined and objectively documented that a patient will not be able to return to his/her former employment and can reasonably prognosticate final restrictions, implementation of a timely vocational assessment can be performed. The vocational assessment should provide valuable guidance in the determination of

future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of Maximum Medical Improvement (MMI) should not be delayed solely due to lack of attainment of a vocational assessment.

i. ...

e. Work Tolerance Screening (Fitness for Duty): is a determination of an individual's tolerance for performing a specific job based on a job activity or task. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. May be used when a full FCE is not indicated.

i. Frequency: One time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1685 (June 2011), amended LR 41:

§2111. Therapeutic Procedures—Non-Operative

A. - B.2.b. ...

c. decrease in usage of medications related to the work injury; and

d. measurable functional gains, such as increased range of motion or documented increase in strength.

3. - 4. ...

C. The following procedures are listed in alphabetical order.

1. Acupuncture

a. When acupuncture has been studied in randomized clinical trials, it is often compared with sham acupuncture and/or with no acupuncture (usual care). The differences between true acupuncture and usual care have been moderate, but clinically important. These differences can be partitioned into two components: nonspecific effects and specific effects. Nonspecific effects, such as patient beliefs and expectations, attention from the acupuncturist, administration of acupuncture in a relaxing setting, and other components of what is often called the placebo effect. Specific effects refer to any additional effects which occur in the same setting of expectations and attention, but are attributable to the penetration of the skin in the specific, classic acupuncture points on the surface of the body by the needles themselves.

b. In most controlled studies the differences between the sham and the classic acupuncture, specific effects of classic acupuncture, have been small in relation to the nonspecific effects. However, the sham controlled studies have shown consistent advantages of both true and sham acupuncture over no acupuncture, when the studies have included a third comparison group which was randomized to usual medical care. Having this third comparison group has been advantageous in the interpretation of the nonspecific effects of acupuncture, since the third comparison group controls for some influences on study outcome including more frequent contact with

providers, the natural history of the condition, regression to the mean, the effect of being observed in a clinical trial, and, if the follow-up observations are done consistently in all three treatment groups, for biased reporting of outcomes. Controlling for these factors enables researchers to more closely estimate the contextual and personal interactive effects of acupuncture as it is generally practiced.

c. Because the sham acupuncture interventions in the clinical trials are generally done by trained acupuncturists, and not by totally untrained personnel, the sham acupuncture interventions may include some of the effects of true acupuncture (Dincer F 2003), much as a partial agonist of a drug may produce some of the effects of the actual drug. For example, a sham procedure involving toothpicks rather than acupuncture needles may stimulate cutaneous afferents in spite of not penetrating the skin, much as a neurological sensory examination may test nociceptor function without skin penetration. To the extent that afferent stimulation is part of the mechanism of action of acupuncture, interpreting the sham results as purely a control group would lead to an underestimation of the analgesic effects of acupuncture. Thus we consider in our analysis that “sham” or non-classic acupuncture may have a positive clinical effect when compared to usual care.

d. Clinical trials of acupuncture typically enroll participants who are interested in acupuncture, and may respond to some of the nonspecific aspects of the intervention more than would be expected of patients who have no interest in or desire for acupuncture. The nonspecific effects of acupuncture may not be produced in patients who have no wish to be referred for it.

e. There is good evidence that both acupuncture and sham acupuncture are superior to usual care without acupuncture for moderate short-term and mild long-term alleviation of low back pain, neck pain, and the pain of joint osteoarthritis (Ernst E 2011; Haake M 2007; Brinkhaus B 2006). In these studies 5 to 15 treatments were provided. Comparisons of acupuncture and sham acupuncture have been inconsistent, and the advantage of true over sham acupuncture has been small in relation to the advantage of sham over no acupuncture”

f. Acupuncture is recommended for chronic pain patients who are trying to increase function and/or decrease medication usage and have an expressed interest in this modality. Acupuncture is not the same procedure as dry needling for coding purposes; however, some acupuncturists may use acupuncture treatment for myofascial trigger points. Dry needling is performed specifically on myofascial trigger points. Refer to Therapeutic Procedures, Non-Operative, Trigger Point Injections and Dry Needling Treatment.

g. Credentialed practitioners with experience in evaluation and treatment of chronic pain patients must perform acupuncture evaluations. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. It may be used when pain medication is reduced or not tolerated; as an adjunct to physical rehabilitation, surgical intervention; and/or as part of multidisciplinary treatment to hasten the return of functional

activity. Acupuncture must be performed by practitioners with the appropriate credentials in accordance with state and other applicable regulations. Therefore, if not otherwise within their professional scope of practice and licensure, those performing acupuncture must have the appropriate credentials, such as L.A.c., R.A.c, or Dipl. Ac.

h. Acupuncture. This is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture has a variety of possible physiologic actions, but their relevance to the clinical response is speculative. For example, one crossover trial measured increasing palmar blood flow and increased nitric oxide synthase activity in arms which had had acupuncture, but this observation may have no bearing on actual analgesic effects (Tsuchiya, 2007).

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

i. Acupuncture with Electrical Stimulation: The use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

ii. There is some evidence that a combination of electrical acustimulation to the wrist combined with neck stretching and strengthening exercises for 30 minutes two times per week for a period of about four weeks demonstrates more improvement in chronic neck pain and patient self-confidence in performing functional activities than neck exercises alone for up to one month (Chan DKC 2009).

j. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Therapeutic Exercise, Massage – Manual or Mechanical, and Superficial Heat and Cold Therapy (excluding Infrared Therapy) for a description of these adjunctive acupuncture modalities and time frames.

k. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

i. Time to Produce Effect: Three to six treatments.

ii. Frequency: One to three times per week.

iii. Optimum Duration: One to two months.

iv. Maximum Duration: 15 treatments.

v. Any of the above acupuncture treatments may extend longer if objective functional gains can be

documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 15 treatments must be documented with respect to need and ability to facilitate positive symptomatic and functional gains. Such care should be re-evaluated and documented with each series of treatments

2. Biofeedback. A form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. There is good evidence that biofeedback and cognitive behavioral therapy are equally effective in managing chronic pain (Hoffman BM 2007). Stress-related psycho-physiological reactions may arise as a reaction to organic pain and in some cases may cause pain. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorily, or tactilely with coaching by a biofeedback specialist.

a. ...

b. Recognized types of biofeedback include the following:

b.i. - c. ...

d. Psychologists or psychiatrists who provide psycho-physiological therapy, which integrates biofeedback with psychotherapy, should be either Biofeedback Certification International Alliance (BCIA) certified or practicing within the scope of their training. All non-licensed health care providers of biofeedback for chronic pain patients must be BCIA certified and shall have their biofeedback treatment plan approved by the authorized treating psychologist or psychiatrist. Biofeedback treatment must be done in conjunction with the patient's psychosocial intervention. Biofeedback may also be provided by health care providers, who follow a set treatment and educational protocol. Such treatment may utilize standardized material or relaxation tapes.

e. Timing/Frequency/Duration

- i. Time to Produce Effect: Three to four sessions.
- ii. Frequency: One to two times per week.
- iii. Optimum Duration: Six to eight sessions.
- iv. Maximum Duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic and functional gains.

3. Disturbances of sleep are common in chronic pain. Although primary insomnia may accompany pain as an independent co-morbid condition, it more commonly occurs secondary to the pain condition itself. Exacerbations of pain often are accompanied by exacerbations of insomnia; the reverse can also occur. Sleep laboratory studies have shown disturbances of sleep architecture in pain patients. Loss of deep slow-wave sleep and increase in light sleep occur and sleep efficiency, the proportion of time in bed spent asleep, is decreased. These changes are associated with patient reports of non-restorative sleep. Sleep apnea may also occur as a primary diagnosis or be caused or exacerbated opioid and hypnotic use. This should be investigated diagnostically (refer to Medications and Medical Management, Opioids).

a. Many chronic pain patients develop behavioral habits that exacerbate and maintain sleep disturbances. Excessive time in bed, irregular sleep routine, napping, low

activity, and worrying in bed are all maladaptive responses that can arise in the absence of any psychopathology. Relaxation training such as progressive relaxation, biofeedback, mindfulness meditation, or imagery training and other forms of cognitive therapy can reduce dysfunctional beliefs and attitudes about sleep (Silber MH 2005). There is some evidence that behavioral modification, such as patient education and group or individual counseling with cognitive behavioral therapy, can be effective in reversing the effects of insomnia (Currie SR 2000). Cognitive and behavioral interventions should be undertaken before prescribing medication solely for insomnia.

b. Behavioral modifications are easily implemented and can include:

i. Maintaining a regular sleep schedule, retiring and rising at approximately the same time on weekdays and weekends;

ii. Limiting naps to 30 minutes twice per day or less;

iii. Avoiding caffeinated beverages after lunchtime;

iv. Making the bedroom quiet and comfortable, eliminating disruptive lights, sounds, television sets, pets, and keeping a bedroom temperature of about 65°F.

v. Avoiding alcohol or nicotine within two hours of bedtime;

vi. Avoiding large meals within two hours of bedtime;

vii. Exercising vigorously during the day, but not within two hours of bedtime, since this may raise core temperature and activate the nervous system;

viii. Associating the bed with sleep and sexual activity only, using other parts of the home for television, reading and talking on the telephone;

ix. Leaving the bedroom when unable to sleep for more than 20 minutes, returning to the bedroom when ready to sleep again;

x. Reducing time in bed to estimated typical sleeping time;

xi. Arising at a regular time each day, regardless of the number of hours slept;

xii. Engaging in relaxing activities until drowsy.

c. Behavioral modifications should be trialed before the use of hypnotics. Reinforcing these behaviors may also decrease hypnotic use and overall medication costs. There is some evidence that group cognitive behavioral therapy reduces the severity and daytime consequences of insomnia for at least six months (Morin CM 2006). Melatonin or ramelteon a longer acting melatonin agonist may be preferred by some patients and is a reasonable alternative to sedative hypnotics. There is some evidence that ramelteon, while producing a small amount of reduction in sleep latency, does not appreciably increase total sleep time or daytime function (Mayer, 2009).

4. Injections—Therapeutic

a. - c. ...

i. Return-to-work or maintaining work status;

ii. Fewer restrictions at work or performing activities of daily living;

iii. Decrease in usage of medications;

iv. Measurable functional gains, such as increased range of motion for documented increase in strength.

d. - e. ...

f. Therapeutic Spinal Injections:

i. Description –The following injections are considered to be reasonable treatment for patients with chronic pain. Other injections not listed may be beneficial. Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology. Injections are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy). Injections by themselves are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active ROM, strength, and stability. If the first injection does not provide a diagnostic response with temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction), and improvement in function, similar injections should not be repeated. Cervical injections are invasive procedures that can cause catastrophic complications. Refer to the Cervical Spine Injury guidelines for more specific contraindications.

ii. Considerations – For all spinal injections (excluding trigger point, botox and occipital or peripheral nerve blocks) multi-planar fluoroscopy, during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner who performs injections for low back pain should document hands on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. The practitioner who performs injections for cervical pain should have completed fellowship training in pain medicine with interventional training, or its equivalent. Practitioners who perform spinal injections must also be knowledgeable of radiation safety.

iii. Complications – General complications of these spinal injections may include transient neurapraxia, local pain, nerve injury, infection, headache, urinary retention and vasovagal effects; epidural hematoma, permanent neurologic damage, dural perforation and cerebral spinal fluid (CSF) leakage, and/or spinal meningial abscess may also occur; Permanent paresis, anaphylaxis and arachnoiditis have been rarely reported with the use of epidural steroids. With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary adrenal axis lasting between one and three months. For cervical injections, severe complications are remote but can include spinal cord damage, quadriplegia, and/or death.

iv. Contraindications - Absolute contraindications of therapeutic injections include: bacterial infection – systemic or localized to region of injection; bleeding diatheses; hematological conditions, and possible pregnancy. Relative contraindications may include allergy to contrast or shellfish; poorly controlled Diabetes Mellitus or hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anticoagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

v. Types of Therapeutic Spinal Injections. The following are in alphabetical order:

(a). Epidural Steroid Injections (ESI):

(i). Description. Epidural steroid injections (ESI) deliver corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation, restoring range-of-motion and thereby facilitating progress in more active treatment programs. ESI uses three approaches: transforaminal, translaminar (midline), and caudal. For ESI in the low back, the transforaminal approach is the preferred method for unilateral, single-level pathology and for post-surgical patients. Also for the low back, there is good evidence that the transforaminal approach can deliver medication to the target tissue with few complications and can be used to identify the specific site of pathology. The interlaminar approach is the preferred approach for multi-level pathology or spinal stenosis in the lumbar spine. Caudal therapeutic injections may be used, but it is difficult to target the exact treatment area, due to diffuse distribution.

(ii). Needle Placement. Multi-planar fluoroscopic imaging is required for all transforaminal epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle placement.

(iii). Indications. There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). Although there is no evidence regarding the effectiveness of ESI for non-radicular pain, it is a generally accepted intervention. Only patients who have pain affected by activity and annular tears verified by appropriate imaging may have injections for axial pain. There is some evidence that ESI injections in the low back are not effective for spinal stenosis without radicular findings. Additionally, there is some evidence in studies of the lumbar spine that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful outcome from ESIs.

(iv). Timing/Frequency/Duration

[a]. Time to Produce Effect: Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

[b]. Frequency: One or more divided levels can be injected in one session. Whether injections are repeated depends upon the patient's response to the previous injection session. Subsequent injection sessions may occur after one to two weeks if there is a positive patient response. Positive patient response results are defined primarily as functional gains that can be objectively

measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

[c]. Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. If the first injection does not provide a diagnostic response of temporary and sustained pain relief (at least two to six weeks) substantiated by accepted pain scales (i.e., 50 percent pain reduction as measured by tools such as VAS) and improvement in function, similar injections should not be repeated.

[d]. Optimum: Usually one up to three injection(s) over a period of six months, depending upon each patient's response and functional gain.

[e]. Maximum: Two sessions (consisting of up to three injections each) may be done in one year based upon the patient's response to pain and function. Patients should be reassessed after each injection session for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

(b). Intradiscal Steroid Therapy: consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic back pain and its use is not recommended.

(c). Sacroiliac Joint Injections:

(i). Description - A generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under radiographic guidance. May include the use of corticosteroids. Long-term therapeutic effect has not yet been established.

(ii). Indications - Primarily diagnostic to rule out sacroiliac joint dysfunction vs. other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick's test) on post-injection physical exam. These injections may be repeated if they result in increased documented functional benefit for at least six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS). Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

(iii.) Timing/Frequency/Duration

[a]. Time to Produce Effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid

[b]. Frequency and Optimum Duration: two injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 80 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection.

[c]. Maximum Duration: three injections per year.

(d). Zygapophyseal (Facet) Injections:

(i). Description. A generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. Medial branch nerve blocks may be diagnostic only. There is conflicting evidence to support a long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

(ii). Indications. Patients with pain, suspected to be facet in origin based on exam findings; and affecting activity; or patients who have refused a rhizotomy; or patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

(iii). ...

(iv). Timing/Frequency/Duration

[a]. Time to Produce Effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

[b]. Frequency: One injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

[c]. Optimum Duration: Two to three injections for each applicable joint per year. Not to exceed two joint levels.

[d]. Maximum Duration: Four per level per year. Prior authorization must be obtained for injections beyond two levels.

g. Other Injections / Procedures –including Radio Frequency. The following are in alphabetical order:

i. Description. The following injections/procedures are considered to be reasonable treatment for patients with chronic pain. Other injections not listed may be beneficial. Therapeutic injections / procedures may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. injections / procedures should be used only after imaging studies and diagnostic injections have established pathology. These are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to. The purpose of therapeutic injections / procedures is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections

/procedures will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy). injections / procedures by themselves are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active ROM, strength, and stability. If the first injections / procedures does not provide a diagnostic response with temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction), and improvement in function, similar injections / procedures should not be repeated.

ii. Types of Other Injections/Procedures

(a). Botulinum Toxin Injections:

(i). Description. Used to temporarily weaken or paralyze muscles. May reduce muscle pain in conditions associated with spasticity, dystonia, or other types of painful muscle spasm. Neutralizing antibodies develop in at least 4 percent of patients treated with botulinum toxin type A, rendering it ineffective. Several antigenic types of botulinum toxin have been described. Botulinum toxin type B, first approved by the Food and Drug Administration (FDA) in 2001, is similar pharmacologically to botulinum toxin type A. It appears to be effective in patients who have become resistant to the type A toxin. The immune responses to botulinum toxins type A and B are not cross-reactive, allowing type B toxin to be used when type A action is blocked by antibody. Experimental work with healthy human volunteers suggests that muscle paralysis from type B toxin is not as complete or as long lasting as that resulting from type A. The duration of treatment effect of botulinum toxin type B for cervical dystonia has been estimated to be 12 to 16 weeks. EMG needle guidance may permit more precise delivery of botulinum toxin to the target area. There is strong evidence that botulinum toxin A has objective and asymptomatic benefits over placebo for cervical dystonia (Costa, [Cochrane], 2005). There is some evidence to support injections for electromyographically proven piriformis syndrome (Fishman, 2002). Prior to consideration of botulinum toxin injection for piriformis syndrome, patients should have had marked (50 percent or better) but temporary improvement with three separate trigger point injections. To be a candidate for botulinum toxin injection for piriformis syndrome, patients should have had symptoms return to baseline or near baseline despite an appropriate stretching program after trigger point injections. Botulinum toxin injections of piriformis should be performed by a physician experienced in this procedure and utilize either ultrasound, fluoroscopy, or EMG needle guidance. Botulinum toxin should be followed by limb strengthening and reactivation.

(ii). Indications. For conditions which produce chronic spasticity, dystonia, or piriformis syndrome. There should be evidence of limited range-of-motion prior to the injection. There is insufficient evidence to support its use other myofascial trigger points for longer-term pain relief and it is likely to cause muscle weakness or atrophy if used repeatedly (Ferrante, 2005; Gobel, 2006; Porta, 2000). Examples of such consequences include subacromial impingement, as the stabilizers of the shoulder are weakened by repeated injections of trigger points in the upper trapezii. Therefore it is not recommended for use for other myofascial trigger points (Abbott 2007).

(iii). Complications. There is good evidence that cervical botulinum toxin A injections cause transient dysphagia and neck weakness. Allergic reaction to medications, dry mouth and vocal hoarseness may also occur Costa J [Cochrane] 2005. Rare systemic effects include flu-like syndrome, and weakening of distant muscle. There is an increased risk of systemic effects in patients with motor neuropathy or disorders of the neuromuscular junction.

(iv). Timing/Frequency/Duration:

[a]. Time to Produce Effect: 24 to 72 hours post injection with peak effect by four to six weeks.

[b]. Frequency: No less than three months between re-administration. Patients should be reassessed after each injection session for an 80 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement for three months. A positive result would include a return to base line function, return to increased work duties, and measurable improvement in physical activity goals including return to baseline after an exacerbation.

[c]. Optimum Duration: Three to four months.

[d]. Maximum Duration: Currently unknown. Repeat injections should be based upon functional improvement and therefore used sparingly in order to avoid development of antibodies that might render future injections ineffective. In most cases, not more than four injections are appropriate due accompanying muscle atrophy.

(b). Dorsal Nerve Root Ganglion Radiofrequency Ablation: Percutaneous radiofrequency partial lesioning of the dorsal root ganglion is a procedure intended to decrease persistent impairing radicular pain. There is some evidence that continuous RF for lumbar radicular pain does not result in improved pain and functional outcomes (Geurts J 2003). Follow up of patients who had a dorsal nerve root ganglia procedure for failed low back surgery reported 2 out of 13 patients had a 50 percent reduction in pain and were satisfied with the procedure at two years. Fifty per cent or more of the group also reported worse sensory and motor findings (North R 1991). There is some evidence from a small study that pulsed RF used in patients with chronic cervical radicular pain who demonstrated a 50 percent reduction in pain on a diagnostic block will provide at least a 50 percent pain relief for three months (Van Zundert J 2007). Recurrence of pain is common after three months with no significant effect at six months (Simopoulos T 2008). No significant improvement in general function was documented. Due to the combination of possible adverse side effects, time limited effectiveness, and mixed study results, this therapy is not recommended. American Society of Anesthesiologist practice guidelines do not recommend routine use (ASA, 2010). This treatment is not recommended.

(c). Epiduroscopy and Epidural Lysis of Adhesions: An investigational treatment of low back pain. It involves the introduction of a fiberoptic endoscope into the epidural space via the sacral hiatus. With cephalad advancement of the endoscope under direct visualization, the epidural space is irrigated with saline. Adhesiolysis may be done mechanically with a fiberoptic endoscope. The saline irrigation is performed with or without epiduroscopy and is

intended to distend the epidural space in order to obtain an adequate visual field. It is designed to produce lysis of adhesions, which are conjectured to produce symptoms due to traction on painful nerve roots. Saline irrigation is associated with risks of elevated pressures which may impede blood flow and venous return, possibly causing ischemia of the cauda equina and retinal hemorrhage. Other complications associated with instrumented lysis include catheter shearing, need for catheter surgical removal, infection (including meningitis), hematoma, and possible severe hemodynamic instability during application. Although epidural adhesions have been postulated to cause chronic low back pain, studies have failed to find a significant correlation between the level of fibrosis and pain or difficulty functioning. Studies of epidural lysis demonstrate no transient pain relief from the procedure. Given the low likelihood of a positive response, the additional costs and time requirement, and the possible complications from the procedure, epidural injection, or mechanical lysis, is not recommended. Epiduroscopy-directed steroid injections are also not recommended as there is no evidence to support an advantage for using an epiduroscope with steroid injections.

(d). Prolotherapy: also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and/or phenol, into the ligamentous structures of the low back and other joints (e.g. it has been used for “stabilization” of ankles, SI joints, etc. Its proponents claim that the inflammatory response to the injections will recruit cytokine growth factors involved in the proliferation of connective tissue, stabilizing the ligaments of the low back or treated joints when these structures have been damaged by mechanical insults. There are conflicting studies concerning the effectiveness of prolotherapy in the low back. Lasting functional improvement has not been shown. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, the use of prolotherapy for low back or other chronic joint pain is not recommended.

(e). Radio Frequency (RF) Neurotomy : (Refer to Cervical Spine and Low Back Pain Medical Treatment Guidelines.)

(f). Trigger Point Injections:

(i). Description - Trigger point injections are a generally accepted treatment. Trigger point injection consists of injection of local anesthetic, with or without corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. There is conflicting evidence regarding the benefit of trigger point injections. There is conflicting evidence regarding the benefit of trigger point injections ([Cochrane] Staal, 2011). A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger point injections. Needling alone may account for some of the therapeutic response. There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

(ii). Indications – Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be

used as an adjunctive treatment in combination with other active treatment modalities. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

[a] For acute exacerbations trigger point injections are indicated in those patients where well-circumscribed trigger points have been consistently observed, demonstrating a local twitch response characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six week timeframe.

(iii). Complications – Potential but rare complications of trigger point injections include infection, pneumothorax, and anaphylaxis, penetration of viscera, neurapraxia and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

(iv). Patients should be reassessed after each injection session for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement for three months. A positive result would include a return to base line function, return to increased work duties, and measurable improvement in physical activity goals including return to baseline after an exacerbation.

(v). Timing/Frequency/Duration

[a]. Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia.

[b]. Frequency: No more than four injection sites per session per week for acute exacerbations only, to avoid significant post-injection soreness.

[c]. Optimum Duration/Maximum: Four sessions per year. Injections may only be repeated when the above functional and time goals are met.

5. Interdisciplinary rehabilitation programs: Are the gold standard of treatment for individuals with chronic pain who have not responded to less intensive modes of treatment. In addition, there are current studies to support the use of pain programs. There is good evidence that interdisciplinary programs, which include screening for psychological issues, identification of fear-avoidance beliefs and treatment barriers, and establishment of individual functional and work goals, patients will improve function and decrease disability (Lambeek, L, 2010; Dobscha, 2009).

a. These programs should assess the impact of pain and suffering on the patient’s medical, physical, psychological, social, and/or vocational functioning. In general, interdisciplinary programs evaluate and treat multiple and sometimes irreversible conditions, including but not limited to painful musculoskeletal, neurological, and other chronic painful disorders and psychological issues, drug dependence, abuse or addiction, high levels of stress

and anxiety, failed surgery; and pre-existing or latent psychopathology. The number of professions involved in the team in a chronic pain program may vary due to the complexity of the needs of the person served. The OWCA recommends consideration of referral to an interdisciplinary program within six months post-injury in patients with delayed recovery unless successful surgical interventions or other medical and/or psychological treatments or complications intervene.

b. Chronic pain patients need to be treated as outpatients within a continuum of treatment intensity. Outpatient chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated among practices by the authorized treating physician (informal). Formal programs are able to provide coordinated, high intensity level of services and are recommended for most chronic pain patients who have received multiple therapies during acute management. Patients with addiction problems or high dose opioid or other drugs of abuse use may require inpatient and/or outpatient chemical dependency treatment programs before or in conjunction with other interdisciplinary rehabilitation. Guidelines from the American Society of Addiction Medicine are available and may be consulted relating to the intensity of services required for different classes of patients in order to achieve successful treatment. Informal interdisciplinary pain programs may be considered for patients who are currently employed, those who cannot attend all day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach, methods, and goals. Generally the type of outpatient program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social and/or vocational functioning.

c. When referring a patient for formal outpatient interdisciplinary pain rehabilitation, an occupational rehabilitation, or an opioid treatment program, the OWCA recommends the program meets the criteria of the Commission on Accreditation of Rehabilitation Facilities (CARF).

d. Inpatient pain rehabilitation programs are rarely needed but may be necessary for patients with any of the following conditions: High risk for medical instability; Moderate-to-severe impairment of physical/functional status; Moderate-to-severe pain behaviors; Moderate impairment of cognitive and/or emotional status; Dependence on medications from which he or she needs to be withdrawn; and the need for 24-hour supervised nursing.

e. Whether formal or informal programs, they should be comprised of the following dimensions (CARF 2010-11):

i. Communication: To ensure positive functional outcomes, communication between the patient, insurer and all professionals involved must be coordinated and consistent. Any exchange of information must be provided to all professionals, including the patient. Care decisions should be communicated to all and should include the family or other support system.

ii. Documentation: Through documentation by all professionals involved and/or discussions with the patient, it

should be clear that functional goals are being actively pursued and measured on a regular basis to determine their achievement or need for modification.

iii. Treatment Modalities: Use of modalities may be necessary early in the process to facilitate compliance with and tolerance to therapeutic exercise, physical conditioning, and increasing functional activities. Active treatments should be emphasized over passive treatments. Active treatments should encourage self-coping skills and management of pain, which can be continued independently at home or at work. Treatments that can foster a sense of dependency by the patient on the caregiver should be avoided. Treatment length should be decided based upon observed functional improvement. For a complete list of active and passive therapies, refer to Therapeutic Procedures, Non-Operative. All treatment timeframes may be extended based upon the patient's positive functional improvement.

iv. Therapeutic Exercise Programs: A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. There is good evidence that exercise alone or part of a multi-disciplinary program results in decreased disability for workers with non-acute low back pain (Oesch P 2010). There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen.

v. Return-to-Work: The authorized treating physician should continually evaluate the patient for their potential to return to work. Return-to-work is described in Therapeutic Procedures, Non-Operative. For patients currently employed, efforts should be aimed at keeping them employed. Formal rehabilitation programs should provide assistance in creating work profiles. For more specific information regarding return-to-work, refer to Return-to-Work (Section 11 in this guideline).

vi. - viii. ...

f. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of the treatment program. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. Programs should have sufficient personnel to work with the individual in the following areas: behavior, functional, medical, cognitive, pain management, psychological, social and vocational.

g. The following programs are listed in alphabetical order.

i. Formal Interdisciplinary Rehabilitation Programs:

(a) ...

(i). The interdisciplinary team maintains consistent integration and communication to ensure that all interdisciplinary team members are aware of the plan of care for the patient, are exchanging information, and implement the plan of care. The team members make interdisciplinary team decisions with the patient and then ensure that decisions are communicated to the entire care team.

(ii). The medical director of the pain program should ideally be board certified in pain management; or be board certified in his or her specialty

area and have completed a one year fellowship in interdisciplinary pain medicine or palliative care recognized by a national board, or have two years experience in an interdisciplinary pain rehabilitation program. Individuals who assist in the accomplishment of functional, physical, psychological, social and vocational goal must include a medical director, pain team physician(s), and pain team psychologist. Other disciplines on the team may include, but are not limited to: Biofeedback Therapist, Occupational Therapist, Physical Therapist, Registered Nurse, case manager, exercise physiologist, psychologist, psychiatrist, and/or nutritionist.

(iii). Timing/Frequency/Duration:

[a]. Time to Produce Effect: Three to four weeks ;

[b]. Frequency: Full time programs - No less than five hours per day, five days per week; part-time programs- four hours per day for two to three days per week;

[c]. Optimum Duration: 3 to 12 weeks at least two to three times a week, with follow up visits weekly or every other week during the first one to two months after the initial program is completed;

[d]. Maximum Duration: Four months for full time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, additional follow up based upon the documented maintenance of functional gains.

(b). Occupational Rehabilitation: is an interdisciplinary program addressing a patient's employability and return-to-work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. A full workday is case specific and is defined by the previous employment of the patient. Safe work place practices and education of the employer and social support system regarding the person's status should be included. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work. There is some evidence that an integrated care programs, consisting of workplace interventions and graded activity teaching that pain need not limit activity, is effective in returning patients with chronic low back pain to work, even with minimal reported reduction of pain (Lambeek L 2010).

(i). The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation, team physicians having experience in occupational rehabilitation, occupational therapy and physical therapy. As appropriate, the team may also include: chiropractor, RN, case manager, psychologist and vocational specialist or certified biofeedback therapist.

(ii). Timing/Frequency/Duration:

[a]. Time to Produce Effect: Two weeks ;

[b]. Frequency: Two to five visits per week, up to eight hours per day;

[c]. Optimum Duration: Two to four weeks;

[d]. Maximum Duration: Six weeks. Participation in a program beyond six weeks must be

documented with respect to need and the ability to facilitate positive symptomatic and functional gains.

ii. Informal Interdisciplinary Rehabilitation Program: A coordinated interdisciplinary pain rehabilitation is one in which the authorized treating physician coordinates all aspects of care. This type of program is similar to the formal programs in that it is goal oriented and provides interdisciplinary rehabilitation services to manage the needs of the patient in the following areas, functional; medical; physical; psychological; social; and vocational.

(a). This program is different from a formal program in that it involves lesser frequency and intensity of services/treatment. Informal rehabilitation is geared toward those patients who do not need the intensity of service offered in a formal program or who cannot attend an all-day program due to employment, daycare, language or other barriers.

(b). Patients should be referred to professionals experienced in outpatient treatment of chronic pain. The OWCA recommends the authorized treating physician consult with physicians experienced in the treatment of chronic pain to develop the plan of care. Communication among care providers regarding clear objective goals and progress toward the goals is essential. Employers should be involved in return to work and work restrictions and the family/social support system should be included in the treatment plan. Other disciplines likely to be involved include biofeedback therapist, occupational therapist, physical therapist, registered nurse, psychologist, case manager, exercise physiologist, psychiatrist, and/or nutritionist.

(c). Time/Frequency/Duration:

(i). Time to Produce Effect: Three to four weeks

(ii). Frequency: Full time programs - no less than five hours per day, five days per week; Part time programs – four hours per day; for two to three days per week.

(iii). Optimum Duration: 3 to 12 weeks at least two to three times a week. With follow up visits weekly or every other week during the first one to two months after the initial program is completed.

(iv). Maximum Duration: Four months, for full time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, additional follow up based upon the documented maintenance of functional gains.

iii. Opioid/Chemical Treatment Programs

(a). Chemical dependency, which for worker compensation issues will usually be related to opioids, anxiolytics, or hypnotics as prescribed for the original workers compensation injury, should be treated with specific programs providing medical and psychological assessment, treatment planning and individual as well group counseling and education.

(b). They may be inpatient or outpatient programs, depending upon the level of intensity of services required. Formal treatment programs are appropriate for patients who have more intense (e.g. use extraordinarily excessive doses of prescription drugs to which they have developed tolerance) or multiple drug abuse issues (e.g.

benzodiazepines and/or alcohol) and those with complex medical conditions or psychiatric issues drug misuse. A medical physician with appropriate training preferably board certified in addiction medicine, should provide the initial evaluation and oversee the program. Full primary assessment should include behavioral health assessment; medical history; physical examination, mental status; current level of functioning; employment history; legal history; history of abuse, violence, and risk taking behavior; education level; use of alcohol, tobacco and other drugs; and social support system (CARF 2010-11).

(c). Addiction counselors, and other trained health care providers as needed, are involved in the program. Peer and group support is an integral part of the program and families are encouraged to attend. There should be good communication between the program and other external services, external health care providers, Alanon, AA and pain medicine providers. Drug screening is performed as appropriate for the individual, minimally initially and at least weekly during the initial detoxification and intensive initial treatment.

(d). Clear withdrawal procedures are delineated for voluntary, against medical advice, and involuntary withdrawal. Withdrawal programs must have a clear treatment plan and include description of symptoms of medical and emotional distress, significant signs of opioid withdrawal, and actions taken. All programs should have clear direction on how to deal with violence in order to assure safety for all participants. Transition and discharge should be carefully planned with full communication to outside resources (CARF 2010-11). Duration of inpatient programs are usually four weeks while outpatient programs may take 12 weeks.

(e). Drug detoxification may be performed on an outpatient or inpatient basis. Detoxification is unlikely to succeed in isolation when not followed by prolonged chemical dependency treatment. Isolated detoxification is usually doomed to failure with very high recidivism rates. Neither ultra-rapid nor rapid-detoxification are recommended due to possible respiratory depression and death and the lack of evidence for long range treatment success.

(f). Abstinence models are preferred by most chemical dependency treatment programs but are problematic for those chronic pain patients who may require the continued use of opioid analgesics. Methadone, buprenorphine, or buprenorphine/naloxone are usually the first line agents for treating such patients; however, continued use in an outpatient setting of methadone for opioid dependency requires dispensing by a licensed methadone clinic and buprenorphine, for the same purpose, by a physician possessing a special DEA license. As of the time of this guideline writing, some formulations of buprenorphine/naloxone have been FDA approved for the treatment of opioid dependence. It is strongly recommended that the use of either drug for the purpose of treating chronic pain be limited to physicians with additional training. In the case of methadone, there are increasing numbers of inadvertent deaths due to misuse, including prescribing errors. In the case of buprenorphine, its use as an analgesic is not currently FDA approved and conversion to this drug from other opioids is difficult. It should never be a first-line

analgesic for chronic pain due to high cost and the presence of other opioids that may be more effective for moderate-to-severe chronic pain.

(g). Tapering opioids on an outpatient basis requires a highly motivated patient and diligent treatment team and may be accomplished by decreasing the current dose 10 percent per day or per week. Tapering should be accompanied by addiction counseling. Failing a trial of tapering a patient should be sent to a formal addiction program. When the dose has reached 1/3 of the original dose, the taper should proceed at half or less of the initial rate. Doses should be held or possibly increased if severe withdrawal symptoms, pain, or reduced treatment failure otherwise occurs. This method is tedious, time consuming and more likely to fail than more rapid and formalized treatment programs.

(h). Timing/Frequency/Duration

(i). Time to Produce Effect: Three to four weeks;

(ii). Frequency: Full time programs- no less than five hours per day, five days per week; part time programs- four hours per day for two to three days per week;

(iii). Optimum Duration: 3 to 12 weeks at least two to three times a week. With follow up visits weekly or every other week during the first one to two months after the initial program is completed;

(iv). Maximum duration: Four months for full time programs and up to six months for part-time programs. Periodic review and monitoring thereafter for one year, additional follow up based upon the documented maintenance of functional gains.

6. Medications and Medical Management. There is no single formula for pharmacological treatment of patients with chronic nonmalignant pain. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. The medication history may consist of evaluating patient refill records through pharmacies to determine if the patient is appropriately taking their prescribed regimen. Appropriate application of pharmacological agents depends on the patient's age, past history (including history of substance abuse), drug allergies and the nature of all medical problems. It is incumbent upon the healthcare provider to thoroughly understand pharmacological principles when dealing with the different drug families, their respective side effects, drug interactions, bioavailability profiles, and primary reason for each medication's usage. Patients should be aware that medications alone are unlikely to provide complete pain relief. In addition to pain relief, a primary goal of drug treatment is to improve the patient's function as measured behaviorally. In addition to taking medications, continuing participation in exercise programs and using self-management techniques such as biofeedback, cognitive behavioral therapy and other individualized physical and psychological practices are essential elements for successful chronic pain management.

a. Control of chronic non-malignant pain is expected to involve the use of medication. Strategies for pharmacological control of pain cannot be precisely specified in advance. Rather, drug treatment requires close monitoring of the patient's response to therapy, flexibility on

the part of the prescriber and a willingness to change treatment when circumstances change. Many of the drugs discussed in the medication section were licensed for indications other than analgesia, but are effective in the control of some types of chronic pain. It is generally wise to begin management with lower cost medications whose efficacy equals higher cost medications and medications with a greater safety profile. Decisions to progress to more expensive, non-generic, and/or riskier products are made based on the drug profile, patient feedback, and improvement in function (WHO [World Health Organization] (n.d.); Ehrlich 2003; Chou 2007). The provider must carefully balance the untoward side effects of the different drugs with therapeutic benefits, as well as monitoring for any drug interactions.

b. Consensus regarding the use of opioids has generally been reached in the field of cancer pain, where nociceptive mechanisms are usually identifiable, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In injured workers, by contrast, central and neuropathic mechanisms frequently overshadow nociceptive processes, expected survival is relatively long, and return to a high level of function is a major goal of treatment. Approaches to pain, which were developed in the context of malignant pain, therefore may not be transferable to chronic non-malignant pain.

c. All medications should be given an appropriate trial in order to test for therapeutic effect. The length of an appropriate trial varies widely depending on the individual drug. Certain medications may take several months to determine the efficacy, while others require only a few doses. It is recommended that patients with chronic nonmalignant pain be maintained on drugs that have the least serious side effects. For example, patients need to be tried or continued on acetaminophen and/or low dose generic antidepressant medications whenever feasible, as part of their overall treatment for chronic pain. Patients with renal or hepatic disease may need increased dosing intervals with chronic acetaminophen use. Chronic use of NSAIDs is generally not recommended due to increased risk of cardiovascular events and GI bleeding. There is good evidence that naproxen has the least risk for cardiovascular events when compared to other NSAIDs (Trelle S 2011). There is good evidence that glucosamine does not improve pain related disability in those with chronic low back pain and degenerative changes on radiologic studies; therefore, it is not recommended for chronic spinal or non-joint pain (Wilkens P 2010). For chronic pain related to joint osteoarthritis see specific extremity guidelines.

d. Opioid analgesics and other drugs of potential abuse such as sedative hypnotics or benzodiazepines may be used in properly selected cases (Gourlay D 2009) for chronic pain patients, although total elimination of these medications is desirable whenever clinically feasible. It is strongly recommended that such pharmacological management be monitored or managed by an experienced pain medicine physician. Multimodal therapy is the preferred mode of treatment for chronic pain patients whether or not these drugs were used acutely or sub-acutely.

e. Neuropathic pain can be treated with a variety of medications; however, all have specific side effects and other interactions that clinicians must be mindful of. It is

suggested that patients with significant peripheral neuropathic pain be trialed with a tricyclic medication initially, as low dose medication in this category is frequently tolerated and performs sufficiently to decrease pain 30 to 50 percent (Wiffen PJ, McQuay, Edwards, [Cochrane] 2005). When these fail, side effects are not tolerated, or a patient has medical issues precluding the use of this class of drugs, other appropriate medications can be tried. Second line drugs include the anti-convulsants, gabapentin and pregabalin. Comparison studies of amitriptyline (Elavil, Endep, Vanatrip) and gabapentin (Fanatrex, Gabarone, Gralise, Horizant, Neurontin) or carbamazepine (Carbatrol, Epitol, Equetro, Tegretol) have shown no appreciable difference between the drugs; thus, there is good evidence that there is little clinical outcome difference between the medications although gabapentin may be better tolerated (Saarto T [Cochrane] 2007; Rowbotham, 2004; Rintala D 2007). Third line drugs are the SNRIs, which have demonstrated some effectiveness for treating neuropathic pain, and topical lidocaine (Moulin DE 2007; O'Connor A 2009). The SNRI duloxetine (Cymbalta, Aricclaim, Xeristar, Yentreve, Duzela) has not been shown to be superior to the tricyclic amitriptyline (Kaur 2011) and there is no reason to prefer duloxetine in patients who have not been treated with a tricyclic. Fourth line drugs are opioids, tramadol (Rybix, Ryzolt, Ultram), and tapentadol (Nucynta). Other medications have few clinical trials to support them but may be helpful in some patients.

f. For the clinician to interpret the following material, it should be noted that: (1) drug profiles listed are not complete; (2) dosing of drugs will depend upon the specific drug, especially for off-label use; and (3) not all drugs within each class are listed, and other drugs within the class may be appropriate for individual cases. Clinicians should refer to informational texts or consult a pharmacist before prescribing unfamiliar medications or when there is a concern for drug interactions. The following drug classes are listed in alphabetical order, not in order of suggested use which is outlined above for neuropathic pain. The preceding principles do not apply to chronic headache patients. These patients should be referred to a physician specializing in the diagnosis and treatment of headache and facial pain.

g. Alpha-Acting Agents: Noradrenergic pain-modulating systems are present in the central nervous system and the alpha-2 adrenergic receptor may be involved in the functioning of these pathways. Alpha-2 agonists may act by stimulating receptors in the substantia gelatinosa of the dorsal horn of the spinal cord, inhibiting the transmission of nociceptive signals. Spasticity may be reduced by presynaptic inhibition of motor neurons. Given limited experience with their use, they cannot be considered first-line or second line analgesics for neurogenic pain, but a trial of their use may be warranted in some cases of refractory pain.

i. Clonidine (Catapres, Kapvay, Nexiclon)

(a). Description – Central Alpha 2 agonist.

(b). Indications – Sympathetically mediated pain, treatment of withdrawal from opioids. IV clonidine and lidocaine should be used for upper extremity surgery with IV regional anesthesia in patients with a history of CRPS as there is some evidence that it decreases the risk of recurrence (Reuben, 2004). As of the time of this guideline

writing, formulations of clonidine have been FDA approved for hypertension.

(c). Major Contraindications – Severe coronary insufficiency, renal impairment.

(d). Dosing and Time to Therapeutic Effect – Increase dosage weekly to therapeutic effect.

(e). Major Side Effects – Sedation, hypotension, sexual dysfunction, thrombocytopenia, weight gain, agitation, rebound hypertension with cessation.

(f). Drug Interactions – Beta adrenergics, tricyclic antidepressants.

(g). Laboratory Monitoring – Renal function, blood pressure.

h. Anticonvulsants: Although the mechanism of action of anticonvulsant drugs in neuropathic pain states remains to be fully defined, some appear to act as nonselective sodium channel blocking agents. A large variety of sodium channels are present in nervous tissue, and some of these are important mediators of nociception, as they are found primarily in unmyelinated fibers and their density increases following nerve injury. While the pharmacodynamic effects of the various anticonvulsant drugs are similar, the pharmacokinetic effects differ significantly. Gabapentin and pre-gabapentin, by contrast, is a relatively non-significant enzyme inducer, creating fewer drug interactions. Because anticonvulsant drugs may have more problematic side-effect profiles, their use should usually be deferred until tricyclic-related medications have failed to relieve pain. All patients on these medications should be monitored for suicidal ideation. Carbamazepine has important effects as an inducer of hepatic enzymes and may influence the metabolism of other drugs enough to present problems in patients taking interacting drugs. There is some evidence that oxcarbazepine (Trileptal) may be effective for neuropathic pain (Dogra, 2005) but dose escalation must be done carefully, since there is good evidence (Dogra, 2005; Beydoun, 2006) that rapid dose titration produces side-effects greater than the analgesic benefits. Carbamazepine is generally not recommended (Moulin, 2007). There is an association between older anticonvulsants including gabapentin and non-traumatic fractures for patients older than 50; this should be taken into account when prescribing these medications (Jette N 2011).

i. Gabapentin (Fanatrex, Gabarone, Gralise, Horizant, Neurontin)

(a). Description – Structurally related to gamma-aminobutyric acid (GABA) but does not interact with GABA receptors.

(b). Indications –As of the time of this guideline writing formulations of gabapentin has been FDA approved for post-herpetic neuralgia and partial seizures. There is some evidence that gabapentin may benefit some patients with post-traumatic neuropathic pain (Gordh T 2008). There is good evidence that gabapentin is not superior to amitriptyline (Rintala D 2007; Saarto T [Cochrane] 2007). There is some evidence that nortriptyline (Aventyl, Pamelor) and gabapentin are equally effective for pain relief of post herpetic neuralgia (Chandra K 2006). There is some evidence that gabapentin given with morphine may result in lower side effects from morphine and produces greater analgesia at lower doses than those usually required for either medication alone (Gilron I 2005). There is strong

evidence that gabapentin is more effective than placebo for neuropathic pain, even though it provides complete pain relief to a minority of patients (Wiffen, Derry, 2005; Irving, 2009). There is some evidence that a combination of gabapentin and nortriptyline provides more effective pain relief than monotherapy with either drug (Gilron 2009). Given the cost of gabapentin it is recommended that patients who are medically appropriate receive a trial of tricyclics before use of gabapentin.

(c). Relative Contraindications – Renal insufficiency. Dosage may be adjusted to accommodate renal dysfunction.

(d). Dosing and Time to Therapeutic Effect – Dosage should be initiated at a low dose in order to avoid somnolence and may require four to eight weeks for titration. Dosage should be adjusted individually.

(e). Major Side Effects – Sedation, confusion, dizziness, peripheral edema. Patients should also be monitored for suicidal ideation and drug abuse.

(f). Drug Interactions – antacids.

(g). Laboratory Monitoring – Renal function.

ii. Pregabalin (Lyrica)

(a). Description – Structurally related to gamma-aminobutyric acid (GABA) but does not interact with GABA receptors.

(b). Indications –As of the time of this guideline writing formulations of pregabalin have been FDA approved for neuropathic pain associated with diabetic peripheral neuropathy, post-herpetic neuralgia, and fibromyalgia. It may also be an adjunctive therapy for partial-onset seizures. There is strong evidence that pregabalin has a substantive benefit for a minority, about 25 percent, of neuropathic pain patients, most of whom report between 30 and 50 percent relief of symptoms (Van Seventer R 2010; Moore RA [Cochrane] 2009). Given the cost of pregabalin and its response for a minority of patients it is recommended that patients who are medically appropriate receive a trial of amitriptyline or another first-line agent before use of pregabalin.

(c). Contraindications – allergy to medication, prior history of angioedema. Renal insufficiency is a relative contraindication, requiring a modified dose.

(d). Dosing and Time to Therapeutic Effect – Dosage may be increased over several days and doses above 150 mg are usually required. The full benefit may not be achieved for six to eight weeks.

(e). Major Side Effects – Dizziness, confusion, sedation, dry mouth, weight gain, and visual changes have been reported. Patients should also be monitored for suicidal ideation and drug abuse. Congestive heart failure may be exacerbated in some patients. Decreased platelets have been reported.

(f). Drug Interactions – Opioids, benzodiazepines, and alcohol.

(g). Laboratory Monitoring – Renal function, and platelets, and creatinine kinase as appropriate for individual cases.

iii. Topiramate (Topamax, Topiragen)

(a). Description – Sulfamate substitute monosacchride.

(b). Indications – FDA approved for partial seizures or prophylaxis for migraines. There is good

evidence that topiramate demonstrates minimal effect on chronic lumbar radiculopathy or other neuropathic pain (Thienel U 2004; Raskin P 2004; Khoromi S 2005). . Therefore it is generally not recommended for chronic pain with the exception of chronic, functionally impairing headache. If it is utilized this would be done as a third or fourth line medication in appropriate patients.

iv. Lamotrigine (Lamictal) – This anti-convulsant drug is not FDA approved for use with neuropathic pain. Due to reported deaths from toxic epidermal necrolysis and Stevens Johnson syndrome, increased suicide risk, and incidents of aseptic meningitis, it is used with caution for patients with seizure or mood disorders. There is good evidence that lamotrigine is not effective for neuropathic pain and that the potential harms are likely to outweigh the benefits, therefore it is not recommended for most patients (Wiffen, 2007 [Cochrane]; Vinik A 2007).

i. Antidepressants: are classified into a number of categories based on their chemical structure and their effects on neurotransmitter systems. Their effects on depression are attributed to their actions on disposition of norepinephrine and serotonin at the level of the synapse; although these synaptic actions are immediate, the symptomatic response in depression is delayed by several weeks. When used for chronic pain, the effects may in part arise from treatment of underlying depression, but may also involve additional neuromodulatory effects on endogenous opioid systems, raising pain thresholds at the level of the spinal cord. Pain responses may occur at lower drug doses with shorter times to symptomatic response than are observed when the same compounds are used in the treatment of mood disorders. Neuropathic pain, diabetic neuropathy, post-herpetic neuralgia, and cancer-related pain may respond to antidepressant doses low enough to avoid adverse effects that often complicate the treatment of depression. First line drugs for neuropathic pain are the tricyclics with the newer formulations having better side effect profiles. SNRIs are considered second line drugs due to their costs and the number needed to treat for a response. SSRIs are used generally for depression rather than neuropathic pain and should not be combined with moderate to high-dose tricyclics (Moulin DE 2007). All patients being considered for anti-depressant therapy should be evaluated and continually monitored for suicidal ideation and mood swings.

i. Tricyclics and older agents (e.g., amitriptyline nortriptyline, doxepin (Adapin, Silenor, Sinequan), desipramine (Norpramin, Pertofrane), imipramine (Tofranil), trazodone Desyrel, Oleptro)).

(a). Description – Serotonergics, typically tricyclic antidepressants (TCAs), are utilized for their serotonergic properties as increasing CNS serotonergic tone can help decrease pain perception in non-antidepressant dosages. Amitriptyline is known for its ability to repair Stage 4 sleep architecture, a frequent problem found in chronic pain patients and to treat depression, frequently associated with chronic pain. However, higher doses may produce more cholinergic side effects than newer tricyclics such as nortriptyline and desipramine. Doxepin and trimipramine also have sedative effects.

(b). Indications –Some formulations are FDA approved for depression and anxiety. For the purposes of this

guideline, they are recommended for neuropathic pain and insomnia. They are not recommended as a drug treatment for depression. There is good evidence that gabapentin is not superior to amitriptyline (Rintala D 2007; Saarto T [Cochrane] 2007). Given the cost of gabapentin it is recommended that patients who are medically appropriate to undergo a trial of lower cost tricyclic before use of gabapentin.

(c). Major Contraindications – Cardiac disease or dysrhythmia, glaucoma, prostatic hypertrophy, seizures, high suicide risk, uncontrolled hypertension and orthostatic hypotension. A screening cardiogram may be done for those 40 or older (O'Connor A 2009), especially if higher doses are used.

(d). Dosing and Time to Therapeutic Effect – Varies by specific tricyclic. Low dosages, less than 100 mg, are commonly used for chronic pain and/or insomnia. Lower doses decrease side effects and cardiovascular risks.

(e). Major Side Effects – Side effects vary according to the medication used; however, the side effect profile for all of these medications is generally higher in all areas except GI distress, which is more common among the SSRIs and SNRIs. Anticholinergic side effects include, but not limited to, dry mouth, sedation, orthostatic hypotension, cardiac arrhythmia, urinary retention, and weight gain. Patients should also be monitored for suicidal ideation and drug abuse.

(f). Drug Interactions – Tramadol (may cause seizures, both also increase serotonin/norepinephrine, so serotonin syndrome is a concern), clonidine, cimetidine (Tagemet), sympathomimetics, valproic acid (Depakene, Depakote, Epilim, Stavzor), warfarin (Coumadin, Jantoven, Marfarin), carbamazepine, bupropion (Aplezin, Budeprion, Buproban, Forfivo, Wellbutrin, Zyban), anticholinergics, quinolones.

(g). Laboratory Monitoring – Renal and hepatic function. EKG for those on high dosages, or with cardiac risk.

ii. Selective serotonin reuptake inhibitors (SSRIs) (e.g., citalopram (Celexa), fluoxetine (Prozac, Rapiflux, Sarafem, Selfemra), paroxetine (Paxil, Pexeva), sertraline (Zoloft)) are not recommended for neuropathic pain. They may be used for depression.

iii. Selective Serotonin Nor-epinephrine Reuptake Inhibitor (SSNRI) / Serotonin Nor-epinephrine Reuptake Inhibitors (SNRI).

(a). Description – Venlafaxine (Effexor), duloxetine, and milnacipran (Savella).

(b). Indications – At the time of this guideline writing, duloxetine has been FDA approved for treatment of diabetic neuropathic pain and chronic musculoskeletal pain. There is good evidence that it is superior to placebo for neuropathic pain at doses of 60mg or 120mg (Lunn M [Cochrane] 2009; Goldstein D 2005). There is some evidence that it is comparable to pregabalin and gabapentin (Quilici, 2009).

As of the time of this guideline writing, formulations of venlafaxine hydrochloride has been FDA approved for generalized anxiety disorder. There is some evidence it is modestly effective in diabetic neuropathic pain at doses of 150 to 225 mg (Rowbotham MC 2004). There is no evidence of superiority over tricyclics. As of the time of this guideline

writing formulations of milnacipran have been FDA approved for treatment of fibromyalgia and has a success rate similar to imipramine. It is not recommended in patients as a first or second line treatment and is reserved for patients who fail other regimes due to side effects.

(c). Relative Contraindications – Seizures, eating disorders.

(d). Major Side Effects - Depends on the drug, but commonly includes dry mouth, nausea, fatigue, constipation, and abnormal bleeding. Serotonin syndrome is also a risk. GI distress, drowsiness, sexual dysfunction less than other classes. Hypertension and glaucoma (venlafaxine). Cardiac issues with venlafaxine and withdrawal symptoms unless tapered (O'Connor A 2009). Studies show increased suicidal ideation and attempts in adolescents and young adults. Patients should also be monitored for suicidal ideation and drug abuse.

(e). Drug Interactions – Drug specific.

(f). Laboratory Monitoring – Drug specific. Hepatic and renal monitoring, venlafaxine may cause cholesterol or triglyceride increases.

iv. Atypical Antidepressants/Other Agents. May be used for depression; however, are not appropriate for neuropathic pain.

j. Hypnotics and Sedatives: Sedative and hypnotic drugs decrease activity, induce drowsiness and may cause moderate agitation in some individuals. Many other medications, such as antihistamines and antidepressants also produce these side effects. Due to the addiction potential, withdrawal symptoms, and sedating side effects, benzodiazepines and other similar drugs found in this class are not generally recommended. They should be used with extreme caution when the patient is on chronic opioids management. When used, extensive patient education should be documented. Some of these medications have long half-lives and sleep apnea can occur or be aggravated on these medications. Many unintentional drug deaths are related to concomitant opioid and benzodiazepine drug use. Retrograde amnesia can occur and is implicated in “sleep driving,” “sleep eating” and other activities. Most insomnia in chronic pain patients should be managed primarily through behavioral interventions, with medications as secondary measures (refer to Disturbances of Sleep).

i. Zaleplon (Sonata), Eszopiclone (Lunesta, Lunestar), Zolpidem (Ambien, Edluar, Intermezzo, Zolpimist).

(a). Description – A nonbenzodiazepine hypnotic.

(b). Indications – As of the time of this guideline writing, formulations of zaleplon, eszopiclone and zolpidem have been FDA approved for insomnia.

(c). Dosing and Time to Therapeutic Effect – Time of onset is 30 to 60 minutes.

(d). Major Side Effects – Dizziness, dose-related amnesia.

(e). Drug Interactions – Increases sedative effect of other central nervous system (CNS) depressant drugs.

(f). Laboratory Monitoring –None required, based on individual patient history.

ii. Benzodiazepine-based hypnotics include temazepam (Restoril, Temazepam, Gelthix) and flurazepam (Dalmane). Neither is recommended because of habit-

forming potential, withdrawal symptoms, and sedating side effects. Flurazepam has an active metabolite with a very long half-life, resulting in drug accumulation and next-day somnolence, and should be avoided.

k. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs and the response of the individual injured worker to a specific medication is unpredictable. For this reason a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advise all NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Administration of proton pump inhibitors, histamine 2 blockers, or misoprostol, a prostaglandin analog, along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. There is good evidence that naproxen has a more favorable cardiovascular risk profile than other NSAIDs when used over a long period for chronic pain (Trelle, 2011). Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete blood count (CBC), liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

i. Non-selective Nonsteroidal Anti-Inflammatory Drugs. Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

(a). Optimal Duration: One to two weeks.

(b). Maximum Duration: Chronic use is not generally recommended but may be appropriate in select cases if monitored regularly. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

ii. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors. COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency; thus, renal function may need monitoring. COX-2 inhibitors should not be first-line for low risk

patients who will be using an NSAID short-term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib (Celebrex) is contraindicated in sulfonamide allergic patients.

(a). Optimal Duration: 7 to 10 days.

(b). Maximum Duration: Chronic use is not generally recommended but may be appropriate in select cases if monitored regularly. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

1. Opioids: are the most powerful analgesics. Their use in acute pain and moderate-to-severe cancer pain is well accepted. Their use in chronic nonmalignant pain, however, is fraught with controversy and lack of scientific research.

i. General Information: Opioids include some of the oldest and most effective drugs used in the control of severe pain. The discovery of opioid receptors and their endogenous peptide ligands has led to an understanding of effects at the binding sites of these naturally occurring substances. Most of their analgesic effects have been attributed to their modification of activity in pain pathways within the central nervous system; however, it has become evident that they also are active in the peripheral nervous system. Activation of receptors on the peripheral terminals of primary afferent nerves can mediate anti-nociceptive effects, including inhibition of neuronal excitability and release of inflammatory peptides. Some of their undesirable effects on inhibiting gastrointestinal motility are peripherally mediated by receptors in the bowel wall.

(a). The central nervous system actions of these drugs account for much of their analgesic effect and for many of their other actions, such as respiratory depression, drowsiness, mental clouding, reward effects, and habit formation. With respect to the latter, it is crucial to distinguish between three distinct phenomena: tolerance, dependence, and addiction.

(b). Tolerance refers to a state of adaptation in which exposure to a drug over time causes higher doses of that drug to be required in order to produce the same physiologic effect and/or markedly diminished effect with continued use of the same amount that drug.

(c). Dependence refers to a set of disturbances in body homeostasis that leads to withdrawal symptoms, which can be produced with abrupt discontinuation, rapid reduction, decreasing blood levels, and/or by administration of an antagonist.

(d). Addiction is a primary, chronic, neurobiological disease, with genetic, psychological, and environmental factors influencing its development and manifestations. It is a behavioral pattern of drug craving and seeking which leads to a preoccupation with drug procurement and an aberrant pattern of use. The drug use is frequently associated with negative consequences.

(e). Tolerance and dependence are physiological phenomena, are expected with the continued administration of opioids, and should not deter physicians from their appropriate use. Before increasing the opioid dose due to a presumption of physiologic tolerance, the physician should

review other possible causes for the decline in analgesic effect. Consideration should be given to possible new psychological stressors or an increase in the activity of the nociceptive pathways. Other possibilities include new pathology, low testosterone level that impedes delivery of opioids to the central nervous system, drug diversion, or abusive use of the medication.

ii. Treatment. The use of opioids is well accepted in treating cancer pain, where nociceptive mechanisms are generally present due to ongoing tissue destruction, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In chronic non-malignant pain, by contrast, tissue destruction has generally ceased, meaning that central and neuropathic mechanisms frequently overshadow nociceptive processes. Expected survival in chronic pain is relatively long and return to a high-level of function is a major goal of treatment. Therefore, approaches to pain developed in the context of malignant pain may not be transferable to chronic non-malignant pain. Opioids are generally not the best choice of medication for controlling neuropathic pain. Tricyclics, SNRIs, and anticonvulsants should be tried before considering opioids for neuropathic pain.

(a). In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. While maximum efficacy is modest, they may reduce pain sufficiently to permit adequate function. When these drugs do not satisfactorily reduce pain, medications specific to the diagnosis should be used, (e.g. neuropathic pain medications as outlined in Medications section).

(b). Most studies show that only around 50 percent of patients tolerate opioid side effects and receive an acceptable level of pain relief. Depending on the diagnosis and other agents available for treatment the incremental benefit can be small (Cepeda M 2007; Landau C 2007, Naliboff B 2010). Patients should have a thorough understanding of the need to pursue many other pain management techniques in addition to medication use in order to function with chronic pain. They should also be thoroughly aware of the side effects and how to manage them. Common side effects are drowsiness, constipation, nausea and possible testosterone decrease with longer term use.

(c). Physicians should be aware that deaths from unintentional drug overdoses exceed the number of deaths from motor vehicle accidents in the US. Most of these deaths are due to the use of opioids, usually in combination with other respiratory depressants such as alcohol or benzodiazepines (Okie, 2010). The prevalence of drug abuse in the population of patients undergoing pain management varies according to region and other issues. A recent study indicated that ¼ of patients being monitored for chronic opioid use have abused drugs occasionally, and ½ of those have frequent episodes of drug abuse (Manchikanti L 2001; 2007). Eighty per-cent of patients admitted to a large addiction program reported that their first use of opioids was from prescribed medication (Cicero 2008).

iii. Choice of Opioids: There is no evidence that one long-acting opioid is more effective than another, nor more effective than other types of medications, in improving function or pain (Chou R 2008). There is some evidence that long-acting oxycodone (Dazidox, Endocodone, ETH-

oxydose, Oxycontin, Oxyfast, OxyIR, Percolone, Roxycodone) and oxymorphone have equal analgesic effects and side effects, although the milligram dose of oxymorphone (Opana) is ½ that of oxycodone (Hale M 2005). There is no evidence that long-acting opioids are superior to short-acting opioids for improving function or pain or causing less addiction (Chou R 2008). Long-acting opioids are generally preferred for chronic opioid management as they are thought to result in a less pronounced euphoria state and are thus less likely to lead to addiction. They may result in better tolerance for the sedative and cognitive effects of opioids. However, due to the lack of evidence, physicians may choose to use short-acting opioids in some patients. Long-acting opioids should not be used for the treatment of acute, sub-acute or post-operative pain, as this is likely to lead to drug dependence and difficulty tapering the medication. Additionally, there is a potential for respiratory depression to occur. When choosing longer acting opioids for chronic pain management it is reasonable to consider cost given the lack of superiority profiles for one medication over another. The Food and Drug Administration (FDA) requires that manufacturers develop Risk Evaluation and Mitigation Strategies (REMS) for most opioids. Physicians should carefully review the plans or educational materials provided under this program.

(a). Addiction and abuse potentials of commonly prescribed opioid drugs may be estimated in a variety of ways, and their relative ranking may depend on the measure which is used. Hydrocodone is the most commonly prescribed opioid in the general population, and is one of the most commonly abused opioids in the population; however, the abuse rate per 1000 prescriptions is lower than the corresponding rates for extended release oxycodone, hydromorphone (Dilaudid, Palladone), and methadone. Extended release oxycodone appears to be the most commonly abused opioid, both in the general population and in the abuse rate per 1000 prescriptions (Cicero T 2007). Tramadol, by contrast, appears to have a lower abuse rate than for other opioids (Cicero T 2005). Newer drug formulations such as oxymorphone, have been assumed to be relatively abuse-resistant, but their abuse potential is unknown and safety cannot be assumed in the absence of sound data (Butler S 2006).

(b). Tapentadol (Nucynta) is a new mu opioid agonist which also inhibits serotonin and norepinephrine reuptake activity. It is currently available in an intermediate release formulation and may be available as extended release if FDA approved. Due to its dual activity it can cause seizures or serotonin syndrome, particularly when taken with other SSRIs, SNRIs, tricyclics, or MAO inhibitors. It has not been tested in patients with severe renal or hepatic damage. It has similar opioid abuse issues as other opioid medication; however, it is promoted as having fewer GI side effects, such as constipation. Further studies may be needed to verify this finding (Sloan P 2010). There is good evidence that extended release tapentadol is more effective than placebo and comparable to oxycodone (Buynak R 2010). In that study the percent of patients who achieved 50 percent or greater pain relief was placebo, 18.9 percent, tapentadol, 27.0 percent, and oxycodone, 23.3 percent. There is some evidence that tapentadol can reduce pain to a moderate degree in diabetic neuropathy, average difference 1.4/10 pain

scale, with tolerable adverse effects (Schwartz S 2011). Tapentadol is not recommended as a first line opioid for chronic, subacute or acute pain due to the cost, lack of superiority over other analgesics and need for further testing to assess GI effects in comparison to other medications. It may be appropriate for patients who cannot tolerate other opioids due to GI side effects.

(c). Methadone requires special precautions. It may cause cardiac arrhythmias due to QT prolongation and has been linked with a greater number of deaths due to its prolonged half life (Chou, Fanciullo, R 2009). Propoxyphene (Darvon, Davon-N, PP-Cap) has been withdrawn from the market due to cardiac effects including arrhythmias.

(d). Fentanyl (Actiq, Duragesic, Fentora, Sublimaze) is not generally recommended for use with musculoskeletal chronic pain patients. It has been associated with a number of deaths and has high addiction potential. Fentanyl should never be used transbuccally in this population.

(e). Meperidine (Demerol) should not be used for chronic pain; it and its active metabolite, normeperidine, present a serious risk of seizure and hallucinations. It is not a preferred medication for acute pain as its analgesic effect is similar to codeine.

(f). Buprenorphine (Suboxone, Subutex) may be used for opioid addiction or habituation treatment in patients with chronic pain, it is not recommended for most chronic pain patients due to methods of administration, reports of euphoria in some patients, and lack of proof for improved efficacy in comparison with other opioids. It may be appropriate for some patients at high risk for addiction and should be used in consultation with an addiction medicine specialist.

iv. Doses of opioids in excess of 120 mg morphine equivalent have been observed to be associated with increased duration of disability, even when adjusted for injury severity in injured workers with acute low back pain and thus any use above 120 mg should be very closely monitored (Webster B 2007; Franklin G 2008). Doses in excess of 200 mg should be avoided (National Opioid Use Guideline Group [NOUGG] 2010). Higher doses are more likely to be associated with hypo-gonadism and the patient should be informed of this risk (NOUGG, 2010). Higher doses of opioids also appear to contribute to the euphoric effect.

(a). Health care professionals and their patients must be particularly conscientious regarding the potential dangers of combining over-the-counter acetaminophen with prescription medications that also contain acetaminophen. Opioid and acetaminophen combination medication are limited due to the acetaminophen component. Total acetaminophen dose per day should not exceed 4 grams per 24-hour period due to possible liver damage.

(b). Physiologic Responses to Opiates: Physiologic responses to opiates are influenced by variations in genes which code for opiate receptors, cytochrome P450 enzymes, and catecholamine metabolism. Interactions between these gene products significantly affect opiate absorption, distribution, and excretion. Hydromorphone, oxymorphone, and morphine are metabolized through the glucuronide system. Other opioids generally use the

cytochrome P450 system (Smith, 2009). Allelic variants in the mu opiate receptor may cause increased analgesic responsiveness to lower drug doses in some patients. The genetic type can predict either lower or higher needs for opioids. For example, at least 10 percent of Caucasians lack the CYP450 2D6 enzyme that converts codeine to morphine (Kosarac, 2009). In some cases genetic testing for cytochrome P450 type may be helpful. When switching patients from codeine to other medications assume the patient has little or no tolerance to opioids. Many gene-drug associations are poorly understood and of uncertain clinical significance; the treating physician needs to be aware of the fact that the patient's genetic makeup may influence both the therapeutic response to drugs and the occurrence of adverse effects. Physicians can expect chronic opioid patients to experience more pain, and require higher doses of opioids, peri-operatively than pre-operatively (Fishbain D 2009).

(c). Risk Factors: Consultation or referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient manifests risk behaviors described below, or when standard treatment measures have not been successful or are not indicated.

v. A psychological consultation including psychological testing (with validity measures) is indicated for all chronic pain patients as these patients are at high risk for unnecessary procedures and treatment and prolonged recovery. Many behaviors have been found related to prescription-drug abuse patients. None of these are predictive alone, and some can be seen in patients whose pain is not under reasonable control; however, the behaviors should be considered warning signs for higher risk of abuse or addiction by physicians prescribing chronic opioids (Webster, 2010). The following behaviors frequently seen in prescription drug - abusing patients should be considered warning signs for addiction and patients that are at high-risk when placed on chronic opioids. In one study four specific behaviors appeared to identify patients at risk for current substance abuse: increasing doses on their own, feeling intoxicated, early refills, and oversedating oneself. A positive test for cocaine also appeared to be related (Fleming, 2008). Consultation with an addiction specialist may be useful when patients present with these symptoms:

- (a). Unusual knowledge of controlled substances;
- (b). Request for specific controlled substances or claims of allergy or ineffectiveness to other medications;
- (c). Demanding assessment or medication after usual clinic hours;
- (d). Requesting more refills than scheduled, "losing" drugs;
- (e). Signs of mood disorders or other psychiatric conditions;
- (f). Physical signs of drug abuse;
- (g). No interest in their diagnosis, fails to keep other treatment or consultation appointments.
- (h). Feigns or exaggerates physical problems;
- (i). Pressures physician by eliciting sympathy, guilt or direct threats (Webster L 2010).

(j). Subjective complaints exceed objective findings.

(k). Attempts to transfers care after a doctor refuses to fill prescription(s) for habit forming medication.

vi. Recommendations for Opioid Use: When considering opioid use for moderate to moderately severe chronic pain, a trial of opioids must be accomplished as described below and the patient must have failed other chronic pain management regimes. Physicians should complete the education recommended by the FDA, risk evaluation and mitigation strategies (REMS) provided by drug manufacturing companies.

(a). General Indications – There must be a clear understanding that opioids are to be used for a limited term as a trial (see trial indications below). The patient should have a thorough understanding of all of the expectations for opioid use. The level of pain relief is expected to be relatively small, two to three points on a VAS pain scale, although in some individual patients it may be higher. For patients with a high response to opioid use, care should be taken to assure that there is no abuse or diversion occurring. The physician and patient must agree upon defined functional goals as well as pain goals. If functional goals are not being met the opioid trial should be reassessed. The full spectrum of side effects should be reviewed. The contract signed by the patient must clarify under what term the opioids will be tapered. See Section iii. D below.

(b). Therapeutic Trial Indications – A therapeutic trial of opioids should not be employed unless the patient has begun multi-disciplinary pain management. Chronic use of opioids should not be prescribed until the following have been met:

(i). The failure of pain management alternatives by a motivated patient including active therapies, cognitive behavioral therapy, pain self-management techniques, and other appropriate medical techniques.

(ii). Physical and psychological and/or psychiatric assessment including a full evaluation for alcohol or drug addiction, dependence or abuse, performed by two specialists including the authorized treating physician and a specialist with expertise in chronic pain. The patient should be stratified as to low, medium or high risk for abuse based on behaviors and prior history of abuse. High risk patients are those with active substance abuse of any type or a history of prescription opioid abuse. These patients should generally not be placed on chronic opioids. If it is deemed appropriate to do so, physician addiction specialists should be monitoring the care. Patients with a past history of substance abuse or other psychosocial risk factors should be co-managed with a physician addiction specialist (Webster, 2010).

(iii). Urine drug screening for substances of abuse and substances currently prescribed. Clinicians should keep in mind that there are an increasing number of deaths due to the toxic misuse of opioids with other medications and alcohol. Drug screening is a mandatory component of chronic opioid management. It is appropriate to screen for alcohol use and have a contractual policy regarding alcohol use during chronic opioid management as alcohol use in combination with opioids is more likely to contribute to death or accidents than marijuana.

(iv). Physician Prescription Drug Monitoring Program review.

(v). Informed, written, witnessed consent by the patient including the aspects noted above.

(vi). The trial, usually with a short-acting agent first, should document sustained improvement of pain control, at least a 30 percent reduction, and of functional status, including return-to-work and/or increase in activities of daily living Farrar, J. T., 2003; Farrar, J. T., 2000). Frequent follow-up at least every two to four weeks may be necessary to titrate dosage and assess clinical efficacy.

vii. On-Going, Long-Term Management - after a successful trial should include:

(a). Prescriptions from a single practitioner;

(b). Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects;

(c). Ongoing effort to gain improvement of social and physical function as a result of pain relief;

(d). Contract detailing the following:

(i). Side effects anticipated from the medication;

(ii). Requirement to continue active therapy;

(iii). Need to achieve functional goals including return to work for most cases;

(iv). Reasons for termination of opioid management, referral to addiction treatment (Rofls R 2010), or for tapering opioids (tapering is usually over 30 days). Examples to be included in the contract include, but are not limited to:

[a]. Diversion of medication

[b]. Lack of functional effect at higher doses

[c]. Non-compliance with other drug use

[d]. Drug screening showing use of drugs outside of the prescribed treatment or evidence of non-compliant use of prescribed medication

[e]. Requests for prescriptions outside of the defined time frames

[f]. Lack of adherence identified by pill count, excessive sedation, or lack of functional gains

[g]. Excessive dose escalation with no decrease in use of short-term medications (NOUGG, 2010; Chou, Fanciullo, 2009).

[h]. Apparent hyperalgesia

[i]. Contracts should be written at a sixth grade reading level to accommodate the majority of patients (Roskos S 2007).

[j]. Use of drug screening initially, randomly at least once a year and as deemed appropriate by the prescribing physician, (Rofls R 2010; NOUGG, 2010; Chou R, Fanciullo, 2009). Drug screening is suggested for any patients who have been receiving opioids for 90 days (Washington State, Agency Medical Directors Group [AMDG], 2010). A discussion regarding how screens positive for marijuana or alcohol will be handled should be included in the opioid contract. The concept of opioid misuse encompasses a variety of problems distinct from the development of addiction, such as nonmedical use, diversion, consultation with multiple prescribers, and unintentional overdose.

[k]. It appears that users of prescription opioids who also experienced depression or anxiety disorders were more likely to abuse opioids (Edlund, M, Steffick, 2007). Urine testing, when included as one part of a structured program for pain management, has been observed to reduce abuse behaviors in patients with a history of drug misuse (Wiedemer NL 2007; Starrels J 2010). Clinicians should keep in mind that there are an increasing number of deaths due to the toxic misuse of opioids with other medications and alcohol. Drug screening is a mandatory component of chronic opioid management. It is appropriate to screen for alcohol use and have a contractual policy regarding alcohol use during chronic opioid management as alcohol use in combination with opioids is more likely to contribute to death or accidents than marijuana.

[l]. Physicians should recognize that occasionally patients may use non-prescribed substances because they have not obtained sufficient relief on the prescribed regime.

[m]. Although drug screens done for chronic pain management should not be routinely available to employers, as screens are part of the treatment record to which employers have limited access, patients should be aware that employers might obtain the records through attorneys or the insurer.

(e). Drug Screening Requirements

(i). Patient signs contract with prescribing physician.

(ii). Only one physician prescribes opioids to injured worker.

(iii). Urine drug screen at beginning of chronic opioid prescribing in non-cancer related chronic or intractable pain.

(iv). All subsequent drugs screens should be random.

(v). Prescribing physician is required to document risk stratification using validated psychometric screening tool. Examples include:

[a]. The Opioid Risk Tool (ORT)

[b]. Pain Medication Questionnaire (PMQ)

[c]. Diagnosis, Intractability, Risk, Efficacy Score (DIRE)

[d]. The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)

[e]. Minimum one random drug screen per year for low risk. Maximum two random drug screens a year for low risk patient, unless physician documents aberrant conduct.

(vi). Maximum four drug screens per year for moderate or high risk patient, unless physician documents aberrant conduct.

(vii). A 1010 Request is not required for the first two drug screens ordered in a calendar year.

(f). Use limited to two oral opioids: a long-acting opioid for maintenance of pain relief and a short-acting opioid for limited rescue use when pain exceeds the routine level. If more than two opioids are being considered for long-term use, a second opinion from specialist who is Board Certified in Addiction, or Pain Medicine is strongly recommended. Short-acting "rescue" medications should be used with caution in patients with a potential for abuse

(Chou, R, Fanciullo, 2009). Buccal-delivered medications should not be used in this population. Transdermal medication use is generally not recommended.

(g). Use of acetaminophen-containing medications in patients with liver disease should be limited, including over the counter medications. Acetaminophen dose should not exceed 4 grams per day for short-term use or 250 mg per day for long-term use in healthy patients (Washington State AMDG, 2010). A safer chronic dose may be 1800mg per day.

(h). Continuing review of overall therapy plan with regard to non opioid means of pain control and functional status.

(i). Monitoring of behavior for signs of possible substance abuse indicating an increased risk for addiction and possible need for consultation with an addiction specialist

(j). Tapering of opioids may be necessary due to the development of hyperalgesia, decreased effects from an opioid, lack of compliance with the opioid contract, or intolerance of side effects. Some patients appear to experience allodynia or hyperalgesia on chronic opioids. This premise is supported by a study of normal volunteers who received opioid infusions and demonstrated an increase in secondary hyperalgesia (NOUGG, 2010). This is thought to be relatively uncommon and more frequently associated with methadone. Options for treating this include withdrawing the patient from opioids and reassessing their condition. In some cases the patient will improve when off of the opioid. In other cases another opioid may be substituted (Chou R, Fanciullo, 2009; Fishbain D 2009; Quigley C [Cochrane] 2004).

viii. Inpatient treatment may be required for addiction or opioid tapering in complex cases. Refer to Interdisciplinary Rehabilitation Programs for detailed information on inpatient criteria.

ix. Relative Contraindications – Extreme caution should be used in prescribing controlled substances for workers with one or more “relative contraindications”: Consultation with a pain or addiction specialist may be useful in these cases.

(a). History of alcohol or other substance abuse, or a history of chronic, benzodiazepine use

(b). Sleep apnea – if patient has symptoms of sleep apnea diagnostic tests should be pursued prior to chronic opioid use.

(c). Off work for more than six months with minimal improvement in function from other active therapy.

(d). Severe personality disorder or other known severe psychiatric disease.

x. General Contraindications (Ballantyne JC 2007; Edlund M, Steffick, 2007; Edlund M, Sullivan, 2007; Webster L 2010): The following are high risk warning signs for possible drug abuse or addiction. Patients with these findings should have a consultation by a pain and or addiction specialist.

(a). Active alcohol or other substance abuse;

(b). Untreated mood or psychotic disorders (e.g., depression);

(c). Decreased physical or mental function with continued opioid use;

(d). Addictive behaviors. Warning signs include but are not limited to:

(i). Preoccupation with drugs;

(ii). Refusal to participate in medication taper;

(iii). Reporting that nothing but a specific opioid works;

(iv). Strong preference for short-acting over long-acting opioids;

(v). Use of multiple prescribers and pharmacies;

(vi). Use of street drugs or other patient’s drugs;

(vii). Not taking medications as prescribed;

(viii). Loss of medications more than once; and/or

(ix). Criminal behaviors to obtain drugs, i.e., forged prescriptions.

xi. Dosing and Time to Therapeutic Effect – Oral route is the preferred route of analgesic administration because it is the most convenient and cost-effective method of administration. Transbuccal administration should be avoided. When patient’s dosage exceeds 120 mg of morphine per day and/or the patient is sedentary with minimal function, consideration should be given to lowering the dosage. Consultation may be necessary. When patients cannot take medications orally, rectal and transdermal routes should be considered because they are also relatively noninvasive. However, careful consideration should be given to the possible abuse potential of these forms of administration.

xii. Major Side Effects – There is great individual variation in susceptibility to opioid-induced side effects and clinicians should monitor for these potential side effects. Common initial side-effects include nausea, vomiting, drowsiness, unsteadiness, and confusion. Occasional side-effects include dry mouth, sweating, pruritus, hallucinations, and myoclonus. Rare side effects include respiratory depression and psychological dependence. Constipation and nausea/vomiting are common problems associated with long-term opioid administration and should be anticipated, treated prophylactically, and monitored constantly. Stool softeners, laxatives and increased dietary fluid may be prescribed. Chronic sustained release opioid use is associated with decreased testosterone in males and females and estradiol in pre-menopausal females. Patients should be asked about changes in libido, sexual function, and fatigue (Rhodin A 2010; Chou R, Fanciullo, 2009).

(a). Sedation - Driving and other tasks – Although some studies have shown that patients on chronic opioids do not function worse than patients not on medication, caution should be exerted and patients should be counseled never to mix opioids with the use of alcohol or other sedating medication. When medication is increased or trials are begun patients should not drive for at least five days (Chou R, Fanciullo, 2009; NOUGG, 2010; “painedu.org”, 2010). Chronic untreated pain and disordered sleep can also impair driving abilities.

(b). Drug Interactions – Patients receiving opioid agonists should not be given a mixed agonist-antagonist such as pentazocine (Talacen, Talwin) or butorphanol

(Stadol) because doing so may precipitate a withdrawal syndrome and increase pain. All sedating medication, especially benzodiazepines should be avoided or limited to very low doses. Over the counter medications such as antihistamines, diphenhydramine, and prescription medications such as hydroxyzine (Anx, Atarax, Atazine, Hypam, Rezine, Vistaril) should be avoided. Alcohol should not be used.

xiii. Recommended Laboratory Monitoring—Primary laboratory monitoring is recommended for acetaminophen/aspirin/NSAIDs combinations (renal and liver function, blood dyscrasias), although combination opioids are not recommended for long-term use. Morphine and other medication may require renal testing and other screening.

xiv. Sleep Apnea Testing- Both obstructive and central sleep apnea is likely to be exaggerated by opioid use or may occur secondary to higher dose chronic opioid use and combination medication use, especially benzodiazepines and sedative hypnotics. Patients should be questioned about sleep disturbance and family members or sleeping partners questioned about loud snoring or gasping during sleep. If present, qualified sleep studies and sleep medicine consultation should be obtained. Portable sleep monitoring units are generally not acceptable for diagnosing primary central sleep apnea. Type 3 portable units with two airflow samples and a O2 saturation device may be useful for monitoring respirator depression secondary to opioids although there are no studies on this topic (Mason: Murray and Nadel's, 2010)

xv. Regular consultation of the Prescription Drug Monitoring Program (PDMP) – Physicians should review their patient on the system whenever drug screens are done. This information should be used in combination with the drug screening results, functional status of the patient and other laboratory findings to review the need for treatment and level of treatment appropriate for the patient.

xvi. Addiction – If addiction occurs, patients may require treatment, Refer to treatment section. After detoxification they may need long-term treatment with naltrexone (Depade, ReVia), an antagonist which can be administered in a long-acting form or buprenorphine which requires specific education per the DEA.

xvii. Potentiating Agents –There is some evidence that dextromethorphan does not potentiate the effect of morphine opioids and therefore is not recommended to be used with opioids (Galer B 2005).

m. Skeletal Muscle Relaxants: are most useful for acute musculoskeletal injury or exacerbation of injury. Chronic use of benzodiazepines is not recommended due to their habit-forming potential and due to seizure risk following abrupt withdrawal, and documented contribution to deaths of patients on chronic opioids due to respiratory depression.

i. Baclofen (intrathecal).

(a). Description – May be effective due to stimulation of Gamma Aminobutyric Acid (GABA) receptors.

(b). Indications – Pain from muscle rigidity. As of the time of this guideline writing, formulations of

baclofen injection have been FDA approved for the management of severe spasticity of a spinal cord or cerebral origin.

(c). Side Effects – exacerbation of psychotic disorders, may precipitate seizures in epileptics, dry mouth, and sexual dysfunction.

(d). Laboratory Monitoring – Renal and hepatic function.

ii. Cyclobenzaprine (Amrix, Fexmid, Flexeril).

(a). Description – Structurally related to tricyclics.

(b). Indications – Acute or exacerbated chronic pain associated with muscle spasm. As of the time of this guideline writing, formulations of this drug are FDA approved as an adjunct to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions. It should only be used for short periods (two to three weeks) because of lack of evidence for effectiveness with prolonged use.

(c). Major Contraindications – Cardiac dysrhythmias

(d). Dosing and Time to Therapeutic Effect – Variable, onset of action is one hour.

(e). Major Side Effects – Sedation, anticholinergic, blurred vision. Patients should also be monitored for suicidal ideation and drug abuse.

(f). Drug Interactions –Contraindicated for use with MAO inhibitors; interacts with tramadol, duloxetine, escitalopram, and fluoxetine. Likely interactions with other ssri's and snri's drug interactions are similar to those for tricyclics. Refer also to tricyclics.

(g). Laboratory Monitoring – Hepatic and renal function.

iii. Carisoprodol (Soma, Soproval, Vanadom). This medication should not be used in chronic pain patients due to its addictive nature secondary to the active metabolite meprobamate (NOUGG, 2010).

iv. Metaxalone (Skelaxin).

(a). Description – Central acting muscle relaxant.

(b). Indications – Muscle spasm. As of the time of this guideline writing, formulations of metaxalone have been FDA approved as an adjunct to rest, physical therapy and other measures for the relief of discomforts associated with acute, painful musculoskeletal conditions.

(c). Major Contraindications – significantly impaired renal or hepatic disease, pregnancy, and disposition to drug induced hemolytic anemia.

(d). Dosing and Time to Therapeutic Effect – Onset of action one hour.

(e). Major Side Effects – sedation, hematologic abnormalities

(f). Drug Interactions – other sedating drugs (e.g. opioids, benzodiazepines)

(g). Laboratory Monitoring – Hepatic Function, CBC

v. Tizanidine (Zanaflex).

(a). Description – Alpha 2 adrenergic agonist.

(b). Indications – Spasticity, musculoskeletal disorders. As of the time of this guideline writing, formulations of tizanidine have been FDA approved for the management of spasticity.

(c). Major Contraindications – Concurrent use with ciprofloxacin (Cipro, Proquin) or fluvoxamine (Luvox); or hepatic disease.

(d). Dosing and Time to Therapeutic Effect – 4 mg per day orally and gradually increase in 2 to 4 mg increments on an individual basis over two to four weeks; maintenance, 8 mg orally every six to eight hours (max dose 36 mg per day).

(e). Major Side Effects – Hypotension, sedation, hepatotoxicity, hallucinations and psychosis, dry mouth.

(f). Drug Interactions – Alcohol can increase sedation. Concurrent use with ciprofloxacin or fluvoxamine contraindicated. Several other medications increase tizanidine plasma concentrations (e.g. oral contraceptives, verapamil, and cimetidine). Use with caution with other alpha agonists, and other antihypertensives as they may increase the risk of hypotension.

(g). Laboratory Monitoring – Hepatic function, blood pressure.

n. Topical Drug Delivery:

i. Description – Topical medications such as lidocaine and capsaicin, may be an alternative treatment for neuropathic disorders and is an acceptable form of treatment in selected patients.

ii. Indications –Neuropathic pain for most agents. Episodic use of NSAIDs and salicylates for joint pain. Patient selection must be rigorous to select those patients with the highest probability of compliance. Many patients do not tolerate the side effects for some medication or the need for frequent application.

iii. Dosing and Time to Therapeutic Effect –All topical agents should be prescribed with strict instructions for application and maximum number of applications per day to obtain the desired benefit and avoid potential toxicity. There is no evidence that topical agents are more or less effective than oral medications. For most patients, the effects of long-term use are unknown and thus may be better used episodically.

iv. Side Effects – Localized skin reactions may occur, depending on the medication agent used.

v. Capsaicin –As of the time of this guideline writing, formulations of capsaicin have been FDA approved for management of pain associated with post-herpetic neuralgia. Capsaicin offers a safe and effective alternative to systemic NSAID therapy. Although it is quite safe, effective use of capsaicin is limited by the local stinging or burning sensation that typically dissipates with regular use, usually after the first 7 to 10 days of treatment. Patients should be advised to apply the cream on the affected area with a plastic glove or cotton applicator and to avoid inadvertent contact with eyes and mucous membranes.

(a). There is good evidence that low dose capsaicin (0.075 percent) applied four times per day will decrease pain up to 50 percent (Derry S [Cochrane] 2009). There is also good evidence that a high dose (8 percent) capsaicin patch applied for 60 minutes can decrease post herpetic neuralgic pain for three months and thus may be useful in other chronic neuropathies (Derry S [Cochrane] 2009; Webster, 2010). The high dose patch is preceded by the application of a lidocaine patch and many patients require a schedule II opioid immediately after the treatment (Webster LR 2010).

vi. Ketamine and Tricyclics – Topical medications, such as the combination of ketamine and amitriptyline have been proposed as an alternative treatment for neuropathic disorders including CRPS. A study using a 10 percent concentration showed no signs of systemic absorption (Finch P 2009). This low-quality study demonstrated decreased allodynia at 30 minutes for some CRPS patients. However, as of the time of this guideline writing, neither tricyclic nor ketamine topicals are FDA approved for topical use in neuropathic pain. Furthermore, there is good evidence that neither 2 percent topical amitriptyline nor 1percent topical ketamine reduces neuropathic pain syndromes (Lynch M 2005). Low dose topical ketamine and topical amitriptyline are not recommended to be used in patients with neuropathic pain syndromes, including CRPS. Physiologically, it is possible that topical tricyclics and a higher dose of ketamine could have some effect on neuropathic pain. The use of topical tricyclics and/or ketamine should be limited to patients with neuritic and/or sympathetically mediated pain with documented supporting objective findings such as allodynia and/or hyperalgesia. Continued use of these agents beyond the initial prescription requires documentation of effectiveness, including functional improvement, and/or decreased use of other medications, particularly decreased use of opiates or other habituating medications.

vii. Lidocaine – As of the time of this guideline writing formulations of lidocaine (patch form) have been FDA approved for pain associated with post-herpetic neuralgia. Evidence is mixed for long-term use of lidocaine topically. Physicians should always take into account the blood level that may be achieved with topical use as toxic levels have been reported (Khaliq W 2007). There is some evidence that a 5percent lidocaine patch may be used as a secondary option for patients with focal neuropathic pain (Meier T 2003). A 30 to 50 percent pain reduction may be achieved in those who tolerate the patch (Meier T 2003). Up to three patches may be used simultaneously for twelve hours per day. It should be applied only to intact skin. Metered dose 8 percent pump sprays have also been used and usually require a three times per day reapplication. There is some evidence that the 8 percent sprays are effective for short-term, two week use (Kanai A 2009). However, the effects of long-term use are unknown.

viii. Topical Salicylates and Nonsalicylates –have been shown to be effective in relieving pain in acute musculoskeletal conditions and single joint osteoarthritis. Topical salicylate and nonsalicylates achieve tissue levels that are potentially therapeutic, at least with regard to COX inhibition. Other than local skin reactions, the side effects of therapy are minimal, although not non-existent and the usual contraindications to use of these compounds needs to be considered. Local skin reactions are rare and systemic effects were even less common. Their use in patients receiving warfarin therapy may result in alterations in bleeding time. Overall, the low level of systemic absorption can be advantageous; allowing the topical use of these medications when systemic administration is relatively contraindicated such as is the case in patients with hypertension, cardiac failure, or renal insufficiency (DOWC [Cumulative Trauma MTG], 2010). There is good evidence that diclofenac gel (Voltaren, Solaraze) reduces pain and improves function in mild-to-moderate hand osteoarthritis

(Altman R 2009). Diclofenac gel has been FDA approved for acute pain due to minor strains, pains, and contusions; and for relief of pain due to osteoarthritis of the joints amenable to topical treatment, such as those of the knees and hands (DOWC [Cumulative Trauma MTG], 2010).

ix. Other Compounded Topical Agents: At the time this guideline was written, no studies identified evidence for the effectiveness of compounded topical agents other than those recommended above. Therefore, other compounded topical agents are not generally recommended. In rare cases they may be appropriate for patients who prefer a topical medication to chronic opioids or have allergies or side effects from other more commonly used oral agents.

x. Prior authorization is required for all agents that have not been recommended above. Continued use requires documentation of effectiveness including functional improvement and/or decrease in other medications.

o. Tramadol (Ultram)

i. Description – An opioid partial agonist that does not cause GI ulceration, or exacerbate hypertension or congestive heart failure. It also inhibits the reuptake of norepinephrine and serotonin which may contribute to its pain relief mechanism. Side effects similar to opioid side effects and may limit its use. They include nausea, sedation and dry mouth.

ii. Indications – Mild to moderate pain relief. As of the time of this guideline writing, formulations of tramadol has been FDA approved for management of moderate to moderately severe pain in adults. This drug has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs (Duehmke RM [Cochrane], 2006). There is some evidence that it alleviates neuropathic pain following spinal cord injury (Norrbrink C 2009). However, given the effectiveness of other drug classes for neuropathic pain tramadol, should not be considered a first line medication. It may be useful for patients who cannot tolerate tricyclic antidepressants.

iii. Contraindications – Use cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as MAO inhibitors, SSRIs, and TCAs. Not recommended in those with prior opioid addiction. Has been associated with deaths in those with an emotional disturbance or concurrent use of alcohol or other opioids. Significant renal and hepatic dysfunction requires dosage adjustment.

iv. Side Effects – May cause impaired alertness or nausea. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation.

v. Drug Interactions – Opioids, sedating medications, any drug that affects serotonin and/or norepinephrine (e.g. SNRI'S, SSRI'S, MAOI'S, and TCA'S).

vi. Laboratory Monitoring – Renal and hepatic function.

p. Glucosamine. There is good evidence that glucosamine does not improve pain related disability in those with chronic low back pain and degenerative changes on radiologic studies, therefore it is not recommended for chronic lower spinal or non-joint pain (Wilkens P 2010). For chronic pain related to joint osteoarthritis see specific extremity guidelines. Glucosamine should not be combined with chondroitin as it is ineffective.

7. Orthotics / Prosthetics / Equipmenty. Devices and adaptive equipment may be necessary in order to reduce impairment and disability, to facilitate medical recovery, to avoid re-aggravation of the injury, and to maintain maximum medical improvement. Indications would be to provide relief of the industrial injury, prevent further injury and control neurological and orthopedic injuries for reduced stress during functional activities. In addition, they may be used to modify tasks through instruction in the use of a device or physical modification of a device. Equipment needs may need to be reassessed periodically. Refer to Return-to-work for more detailed information.

a. Equipment may include high and low technology assistive devices, computer interface or seating, crutch or walker training, and self-care aids. It should improve safety and reduce risk of re-injury. Standard equipment to alleviate the effects of the injury on the performance of activities of daily living may vary from simple to complex adaptive devices to enhance independence and safety. Certain equipment related to cognitive impairments may also be required.

b. Ergonomic modifications may be necessary to facilitate medical recovery, to avoid re-aggravation of the injury, and to maintain maximum medical improvement. Ergonomic evaluations with subsequent recommendations may assist with the patients' return-to-work. (Refer to Jobsite Evaluation for further information.)

c. For chronic pain disorders, equipment such as foot orthoses may be helpful. The injured worker should be educated as to the potential harm from using a lumbar support for a period of time greater than which is prescribed. Harmful effects include de-conditioning of the trunk musculature, skin irritation, and general discomfort. Use of cervical collars is not recommended for chronic cervical myofascial pain. Special cervical orthosis and/or equipment may have a role in the rehabilitation of a cervical injury such as those injuries to a cervical nerve root resulting in upper extremity weakness or a spinal cord injury with some degree of paraparesis or tetraparesis. Use of such devices would be in a structured rehabilitation setting as part of a comprehensive rehabilitation program.

d. Fabrication/modification of orthotics, including splints, would be used when there is need to normalize weight-bearing, facilitate better motion response, stabilize a joint with insufficient muscle or proprioceptive/reflex competencies, to protect subacute conditions as needed during movement, and correct biomechanical problems. Orthotic/prosthetic training is the skilled instruction (preferably by qualified providers) in the proper use of orthotic devices and/or prosthetic limbs.

e. For information regarding specific types of orthotics/prosthetics/equipment, refer to individual medical treatment guidelines.

8. Patient Education. Patients should be educated on their specific injury, assessment findings, and plan of treatment and encouraged to take an active role in establishing functional outcome goals. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of rehabilitation, as well as facilitating self-management of symptoms and prevention of secondary disability. In some cases, educational intervention combined

with exercises may achieve results comparable to surgical intervention for patients who have undergone previous surgery. There is some evidence that, for patients who had undergone previous surgery for disc herniation and continued to experience low back pain for at least one year, educational lectures and materials provided to the patients in conjunction with exercise programs yield similar results as indicated by Oswestry Disability scores to patients who had undergone posterolateral low back fusion. It should be noted that the rehabilitation program included individual and group discussions targeted to assuring patients that participation in ordinary activities would not cause harm. Treatment period was 25 hours per week for three weeks (Brox JI 2010).

a. Patient education is an interactive process that provides an environment where the patient not only acquires knowledge but also gains an understanding of the application of that knowledge. Therefore, patients should be able to describe and/or will need to be educated on:

- i. The treatment plan;
- ii. Indications for and potential side effects of medications.
- iii. Their home exercise program;
- iv. Expected results of treatment;
- v. Tests to be performed, the reasons for them and their results;
- vi. Activity restrictions and return-to-work status;
- vii. Home management for exacerbations of pain;
- viii. Procedures for seeking care for exacerbations after office hours;
- ix. Home self-maintenance program;
- x. Patient responsibility to communicate with all medical providers and the employer;
- xi. Patient responsibility to keep appointments;
- xii. The importance of taking medications exactly as prescribed; and
- xiii. Basic physiology related to patient's diagnosis.

b. Educational efforts should also target family and other support persons, the case manager, the insurer, and the employer as indicated to optimize the understanding of the patient and the outcome. Professional translators should be provided for non-English speaking patients to assure optimum communication. All education, teaching, and instruction given to the patient should be documented in the medical record. Effects of education weaken over time; continuing patient education sessions will be required to maximize the patient's function. The effectiveness of educational efforts can be enhanced through attention to the learning style and receptivity of the patient. Written educational materials may reinforce and prolong the impact of verbal educational efforts. Overall, patient education should emphasize health and wellness, return-to-work and return to a productive life.

c. Timing/Frequency

- i. - ii. ...

9. Psychological / Psychosocial Intervention

a. Psychosocial treatment is a well-established therapeutic and diagnostic intervention with selected use in acute pain problems, and more widespread use in sub-acute and chronic pain populations. Psychosocial treatment is recommended as an important component in the total management of a patient with chronic pain and should be implemented as soon as the problem is identified.

Psychological treatment should focus on both symptomatic and functional improvements. Psychological treatment should include focus on Return to Work and the prevention of disability.

b. If a diagnosis consistent with commonly accepted psychiatric/psychological standards has been determined, the patient should be evaluated for the potential need for psychiatric medications. Use of any medication to treat a diagnosed condition may be ordered by the authorized treating physician, the consulting Psychiatrist, or a licensed Psychologist. Visits for management of psychiatric medications are medical in nature and are not a component of psychosocial treatment. Therefore, separate visits for medication management may be necessary, depending upon the patient and medications selected.

c. Psychosocial interventions include psychotherapeutic treatments for mental health conditions, as well as behavioral medicine treatments for patients without psychiatric conditions, but who may need to make major life changes in order to cope with pain or adjust to disability. Examples of these treatments include cognitive behavioral therapy, relaxation training, mindfulness training, and sleep hygiene training.

d. The screening or diagnostic workup should have clarified and distinguished between pre-existing, aggravated, and/or purely causative psychological conditions. Therapeutic and diagnostic modalities include, but are not limited to, individual counseling, and group therapy. Treatment can occur within an individualized model, a multi-disciplinary model, or within a structured pain management program.

e. A licensed psychologist, or a Psychiatric MD/DO may perform psychosocial treatments. Other licensed mental health providers or licensed health care providers with training in cognitive behavior therapy (CBT), or certified as CBT therapists working in consultation with a licensed Psychologist or Psychiatric MD/DO; and with experience in treating chronic pain disorders in injured workers may also perform treatment.

f. CBT refers to a group of psychological therapies that are sometimes referred to by more specific names, such as Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy. Variations of CBT methods can be used to treat a variety of conditions, including chronic pain, depression, anxiety, phobias, and post-traumatic stress disorder (PTSD). For patients with multiple diagnoses, more than one type of CBT might be needed. The CBT used in research studies is often "manualized CBT," meaning that the treatment follows a specific protocol in a manual (Thorn, 2004). In clinical settings, CBT may involve the use of standardized materials, but it is also commonly adapted by a psychologist or psychiatrist to the patient's unique circumstances. If the CBT is being performed by a non-mental health professional, a manual approach would be strongly recommended. CBT must be distinguished from neuropsychological therapies used to teach compensatory strategies to brain injured patients, which are also called "cognitive therapy."

g. It should be noted that most clinical trials on CBT exclude subjects who have significant psychiatric diagnoses. Consequently, the selection of patients for CBT

should include the following considerations. CBT is instructive and structured, using an educational model with homework to teach inductive rational thinking. Because of this educational model, a certain level of literacy is assumed for most CBT protocols. Patients who lack the cognitive and educational abilities required by a CBT protocol are unlikely to be successful. Further, given the highly structured nature of CBT, it is more effective when a patient's circumstances are relatively stable. For example, if a patient is about to be evicted, is actively suicidal, or is coming to sessions intoxicated, these matters will generally preempt CBT treatment for pain, and require other types of psychotherapeutic response. Conversely, literate patients whose circumstances are relatively stable, but who catastrophize or cope poorly with pain or disability are often good candidates for CBT for pain. Similarly, literate patients whose circumstances are relatively stable, but who exhibit unfounded medical phobias, are often good candidates for CBT for anxiety.

h. There is good evidence that cognitive intervention reduces low back disability in the short term and in the long term. In one of the studies the therapy consisted of six, two hour sessions given weekly to workers who had been sick-listed for 8 to 12 weeks. Comparison groups included those who received routine care (Storheim, 2003; Linton, 2005). There is good evidence that psychological interventions, especially CBT, are superior to no psychological intervention for chronic low back pain, and that self-regulatory interventions, such as biofeedback and relaxation training, may be equally effective (Hoffman, 2007). There is good evidence that six group therapy sessions lasting one and a half hours each focused on CBT skills improved function and alleviated pain in uncomplicated sub-acute and chronic low back pain patients (Lamb, 2010). There is some evidence that CBT provided in seven two-hour small group sessions can reduce the severity of insomnia in chronic pain patients (Currie, 2000). A Cochrane meta-analysis grouped very heterogeneous behavioral interventions and concluded that there was good evidence that CBT may reduce pain and disability but the effect size was uncertain ([Cochrane] Eccleston, 2009). In total, the evidence clearly supports CBT, and it should be offered to all chronic pain patients who do not have other serious issues, as discussed above.

i. CBT is often combined with active therapy in an interdisciplinary program, whether formal or informal. It must be coordinated with a psychologist or psychiatrist. CBT can be done in a small group or individually, and the usual number of treatments varies between 8 and 16 sessions.

j. Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or psychiatric MD/DO.

k. Psychological Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis I disorders are common in chronic pain. One study demonstrated that the majority of patients who had failed other therapy and participated in an active therapy program also suffered from major depression. However, in a program that included CBT and other psychological counseling, the success rate for return to work was similar for those with and without a DSM IV diagnosis.

This study further strengthens the argument for having some psychological intervention included in all chronic pain treatment plans (Gatchel, 1994).

l. For all psychological/psychiatric interventions, an assessment and treatment plan with measurable behavioral goals, time frames, and specific interventions planned, must be provided to the treating physician prior to initiating treatment. A status report must be provided to the authorized treating physician every two weeks during initial more frequent treatment and monthly thereafter. The report should provide documentation of progress towards functional recovery and discussion of the psychosocial issues affecting the patient's ability to participate in treatment. The report should also address pertinent issues such as pre-existing, aggravated, and/or causative, as well as project realistic functional prognosis.

m. Cognitive Behavioral Therapy (CBT) or Similar Treatment: Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed psychologist or psychiatric MD/DO.

i. Timing/Frequency/Duration

(a). Time to Produce Effect: six to eight, one to two-hour session, group or individual, one-hour individual or two-hour group.

(b). Maximum Duration: 16 sessions.

(c). NOTE: Before CBT is done, the patient must have a full psychological evaluation. The CBT program must be done under the supervision of a licensed Psychologist or Psychiatric MD/DO.

n. Other psychological/psychiatric interventions:

i. Timing/Frequency/Duration

(a). Time to Produce Effect: Six to eight weeks.

(b). Frequency: One to two times weekly for the first two weeks (excluding hospitalization, if required), decreasing to one time per week for the second month. Thereafter, two to four times monthly with the exception of exacerbations which may require increased frequency of visits. Not to include visits for medication management

(c). Optimum Duration: Two to six months.

(d). Maximum: Six months. Not to include visits for medication management. For select patients, longer supervised psychological/psychiatric treatment may be required, especially if there are ongoing medical procedures or complications. If counseling beyond six months is indicated, the management of psychosocial risks or functional progress must be documented. Treatment plan/progress must show severity.

10. Restriction of Activities. Continuation of normal daily activities is the recommendation for chronic pain patients since immobility will negatively affect rehabilitation. Prolonged immobility results in a wide range of deleterious effects, such as a reduction in aerobic capacity and conditioning, loss of muscle strength and flexibility, increased segmental stiffness, promotion of bone demineralization, impaired disc nutrition, and the facilitation of the illness role.

a. Immobility may range from bed rest to the continued use of orthoses, such as cervical collars and lumbar support braces. While these interventions may have been ordered in the acute phase, the provider should be aware of their impact on the patient's ability to adequately

comply with and successfully complete rehabilitation. There is strong evidence against the use of bed rest in acute low pain back cases without neurologic symptoms (Malmivaara A 1995; Hagen EM 2000).

b. Patients should be educated to the detrimental effects of immobility versus the efficacious use of limited rest periods. Adequate rest allows the patient to comply with active treatment and benefit from the rehabilitation program. In addition, complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation and promotes disability. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with chronic pain.

11. Return-to-Work, and/or work-related activities whenever possible is one of the major components in chronic pain management and rehabilitation. There is some evidence that an integrated care program including workplace interventions and graded activity teaching that pain need not limit activity, is effective in returning patients with chronic low back pain to work, even with minimal reduction of pain (Lambeek LC 2010). Return-to-work is a subject that should be addressed by each workers' compensation provider at the first meeting with the injured employee, and be updated at each additional visit. A return-to-work format should be part of a company's health plan, knowing that return-to-work can decrease anxiety, reduce the possibility of depression, and reconnect the worker with society.

a. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset. In complex cases, experienced nurse case managers may be required to assist in return-to-work. Other services, including psychological evaluation and/or treatment, jobsite analysis, and vocational assistance may be employed.

b. Two counseling sessions with an occupational physician, and work site visit if necessary, may be helpful for workers who are concerned about returning to work (Jensen, 2012b). Another study found that low back pain claimants who received information on self-care and return to work had fewer episodes of relapse than those who did not receive the advice (DuBois, 2012).

c. At least one study suggest that health status is worse for those who do not return to work than those who do. Self-employment and injury severity predict return to work. Difficulty with pain control, ADLs, and anxiety and depression were common (Kendrick, 2012).

d. The following should be considered when attempting to return an injured worker with chronic pain to work.

i. - ii. ...

iii. Communication: is essential between the patient, authorized treating physician, employer, and insurer. Employers should be contacted to verify employment status, job duties and demands, and policies regarding injured workers. In addition, availability of temporary and permanent restrictions, for what duration, as well as other placement options should be discussed and documented. All communications in the absence of the patient are required to be documented and made available to the patient.

iv. Establishment of Return-To-Work Status: Return-to-work for persons with chronic pain should be thought of as therapeutic, assuming that work is not likely to aggravate the basic problem or increase the discomfort. In most cases of chronic pain, the worker may not be currently working or even employed. The goal of return-to-work would be to implement a plan of care to return the worker to any level of employment with the current employer or to return them to any type of new employment.

v. Establishment of Activity Level Restrictions: A formal job description for the injured/ill employee who is employed is necessary to identify physical demands at work and assist in the creation of modified duty. A jobsite evaluation may be utilized to identify tasks such as pushing, pulling, lifting, reaching above shoulder level, grasping, pinching, sitting, standing, posture, ambulatory distance and terrain, and if applicable, environment for temperature, air flow, noise and the number of hours that may be worked per day. Due to the lack of predictability regarding exacerbation of symptoms affecting function, an extended, occupationally focused functional capacity evaluation may be necessary to determine the patient's tolerance for job type tasks over a continuing period of time. Functional Capacity Evaluations should usually take place for eight hours. Between one and three days after the evaluation, there should be a follow-up evaluation by the treating therapist and/or the authorized treating physician to assess the patient's status. When prescribing the FCE, the physician must assess the probability of return to work against the potential for exacerbation of the work related condition. Work restrictions assigned by the authorized treating physician may be temporary or permanent. The case manager should continue to seek out modified work until restrictions become less cumbersome or as the worker's condition improves or deteriorates.

vi. ...

vii. Vocational Assistance: Formal vocational rehabilitation is a generally accepted intervention and can assist disabled persons to return to viable employment. Assisting patients to identify vocational goals will facilitate medical recovery and aid in the maintenance of MMI by 1) increasing motivation towards treatment and 2) alleviating the patient's emotional distress. Chronic pain patients will benefit most if vocational assistance is provided during the interdisciplinary rehabilitation phase of treatment. To assess the patient's vocational capacity, a vocational assessment utilizing the information from occupational and physical therapy assessments may be utilized to identify rehabilitation program goals, as well as optimize both patient motivation and utilization of rehabilitation resources. This may be extremely helpful in decreasing the patient's fear regarding an inability to earn a living which can add to their anxiety and depression.

viii. Recommendations to employers and employees of small businesses: employees of small businesses who are diagnosed with chronic pain may not be able to perform any jobs for which openings exist. Temporary employees may fill those slots while the employee functionally improves. Some small businesses hire other workers and if the injured employee returns to the job, the supervisor/owner may have an extra employee. To avoid this, it is suggested that case managers be accessed through

their payer or third party administrator. Case managers may assist with resolution of these problems, as well as assist in finding modified job tasks, or find jobs with reduced hours, etc., depending upon company philosophy and employee needs.

ix. Recommendations to Employers and Employees of Mid-Sized and Large Businesses – Employers are encouraged by the OWCA to identify modified work within the company that may be available to injured workers with chronic pain who are returning to work with temporary or permanent restrictions. To assist with temporary or permanent placement of the injured worker, it is suggested that a program be implemented that allows the case manager to access descriptions of all jobs within the organization.

12. Therapy – Active: The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range-of-motion, and can alleviate discomfort. All active therapy plans should be made directly with patients in the interest of achieving long-term individualized goals. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). Active therapy is intended to promote independence and self-reliance in managing the physical pain as well as to improve the functional status in regard to the specific diagnosis and general conditioning and well-being. At times, a provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient. Therapy in this section should not be merely a repeat of previous therapy but should focus specifically on the individual goals and abilities of the patient with chronic pain.

a. The goal of active therapy is to teach the patient exercises that they can perform regularly on their own. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

b. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" has been completed, then alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

c. The following active therapies are listed in alphabetical order:

i. Activities of Daily Living (ADLs): Well-established interventions that involve instruction, active-assisted training, and/or adaptation of activities or equipment

to improve a person's capacity in normal daily activities, such as self-care, work re-integration training, homemaking, and driving.

(a). Timing/Frequency/Duration:

(i). Time to Produce Effect: Four to five treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

ii. Aquatic Therapy: A well-accepted treatment that consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, ROM, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool heated to 88 to 92 degrees. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

(a). Cannot tolerate active land-based or full-weight bearing therapeutic procedures;

(b). Require increased support in the presence of proprioceptive deficit;

(c). Are at risk of compression fracture due to decreased bone density;

(d). Have symptoms that are exacerbated in a dry environment;

(e). Have a higher probability of meeting active therapeutic goals than in a dry environment.

(f). The pool should be large enough to allow full extremity range of motion and fully erect posture. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

(g). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to five treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

(h). A self-directed program is recommended after the supervised aquatics program has been established. Best practice suggests that the patient be transitioned to a dry environment exercises which may or may not be self-directed, after four to six weeks unless vocation involves significant time in the water. The transition to dry land may evolve over the course of weeks.

iii. Functional Activities: are well-established interventions which involve the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, and sensory motor integration.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to five treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

iv. Functional Electrical Stimulation: is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. Indications include muscle atrophy, weakness, and sluggish muscle contraction secondary to pain, injury, neuromuscular dysfunction, peripheral nerve lesion, or radicular symptoms. This modality may be prescribed for use at home when patients have demonstrated knowledge of how to self-administer and are in an independent exercise program.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Eight weeks.

(iv). Maximum Duration: Eight weeks. If beneficial, provide with home unit.

v. Spinal Stabilization: is a generally well-accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neutral and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to eight treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Eight weeks.

vi. Neuromuscular Re-education: is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns, neuromuscular response, proprioception, kinesthetic sense, coordination; education of movement, balance and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Eight weeks.

vii. Therapeutic Exercise: with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength; improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception, and coordination, and increased range of motion are used to promote normal movement patterns. May also include alternative/complementary exercise movement

therapy (with oversight of a physician or appropriate healthcare professional).

(a). There is some evidence that Iyengar yoga, which avoids back bending, results in improved function and decreased chronic mechanical low back pain for up to six months. One quarter of the participants dropped out. Instruction occurred two times per week for 24 weeks and was coupled with home exercise (Williams K 2009). Yoga may be an option for motivated patients. 48 sessions is the maximum expected duration and time to effect is eight sessions. There is some evidence that intensive exercise coupled with cognitive behavioral therapy is as effective for chronic un-operated low back pain as posterolateral fusion (Brox JI 2010). There is good evidence that exercise alone or part of a multi-disciplinary program results in decreased disability for workers with non-acute low back pain (Oesch P 2010).

(b). Therapeutic exercise programs should be tissue specific to the injury and address general functional deficits as identified in the diagnosis and clinical assessment. Patients should be instructed in and receive a home exercise program that is progressed as their functional status improves. Upon discharge, the patient would be independent in the performance of the home exercise program and would have been educated in the importance of continuing such a program. Educational goals would be to maintain or further improve function and to minimize the risk for aggravation of symptoms in the future.

(c). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to eight weeks and concurrent with an active daily home exercise program.

(iv). Maximum Duration: 8 to 12 weeks of therapist oversight. Home exercise should continue indefinitely.

viii. Work Conditioning: These programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full- or optimal-function and return to work. The service may include the time-limited use of modalities, both active and passive, in conjunction with therapeutic exercise, functional activities, general conditioning body mechanics, and lifting techniques re-training. These programs are usually initiated once re-conditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified- or full-duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(a). Timing/Frequency/Duration

(i). Length of Visit: One to two hours per day.

(ii). Frequency: Two to five visits per week.

(iii). Optimum Duration: Two to four weeks.

(iv). Maximum Duration: Six weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic and functional gains.

ix. Work Simulation: is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a functional capacity evaluation and/or jobsite analysis.

(a). Timing/Frequency/Duration

(i). Length of Visit: Two to six hours per day.

(ii). Frequency: Two to five visits per week.

(iii). Optimum Duration: Two to four weeks.

(iv). Maximum Duration: Six weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic and functional gains.

13. Therapy – Passive: Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies such as postural stabilization and exercise programs to help control swelling, pain, and inflammation during the active rehabilitation process. Please refer to General Guideline Principles, Active Interventions. Passive therapies may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment; or if there are episodes of acute pain superimposed upon a chronic pain problem.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may extend durations of care. Having specific goals with objectively measured functional improvement during treatment can support extended durations of care. It is recommended that if after six to eight visits no treatment effect is observed, alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

b. The following passive therapies are listed in alphabetical order:

i. Electrical Stimulation (Unattended): An accepted treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include muscle spasm, atrophy, and the need for osteogenic stimulation.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Varies, depending upon indication, between two to three times per day to one time per week. A home unit should be purchased if treatment is effective and frequent use is recommended.

(iii). Optimum and Maximum Duration: Four treatments for clinic use.

ii. Intramuscular Manual Therapy: Trigger Point Dry Needling. IMT involves using filament needles to treat "Trigger Points" within muscle. It may require multiple advances of a filament needle to achieve a local twitch response to release muscle tension and pain. Dry needling is an effective treatment for acute and chronic pain of neuropathic origin with very few side effects. Dry needling is a technique to treat the neuro-musculoskeletal system based on pain patterns, muscular dysfunction and other orthopedic signs and symptoms:

(a). Timing/Frequency/Duration

(i). Time to produce effect: Immediate

(ii). Frequency: One to two times a week

(iii). Optimum duration: Six weeks

(iv). Maximum Duration: Eight weeks

iii. Iontophoresis: is an accepted treatment which consists of the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, and salicylate), ischemia (magnesium, mecholy, and iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars and keloids (chlorine, iodine, acetate).

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to four treatments.

(ii). Frequency: Three times per week with at least 48 hours between treatments.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

iv. Manipulation: Manipulative Treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(a). There is good evidence that a combination of exercise and spinal manipulation is more effective than manipulation alone in relieving chronic neck pain, and that these advantages remain for more than one year after the end of treatment (Bronfort 2001, Evans 2002). Conversely, there is some evidence that a combination of spinal manipulation and exercise is more effective than exercise alone in reducing pain and improving function of low back pain for one year (Aure 2003).

(b). There is good evidence that spinal manipulation has a small superiority to other common interventions (standard medical care, physiotherapy, and exercise alone) for chronic low back pain, making it comparable to other commonly accepted interventions for this indication (Rubinstein 2011).

(c). The decision to refer a patient for spinal manipulation rather than for other treatments should be made on the basis of patient preference and relative safety, not on an expectation of a greater treatment effect. Manipulation may be indicated in patients who have not had an evaluation for manual medicine, or have not progressed adequately in an exercise program.

(d). Manipulative treatments may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical doctors (M.D.). Some popular and useful techniques include, but are not limited to, high velocity, low amplitude (HVLA), muscle energy (ME), strain-counterstrain (SCS), a balanced ligamentous tension (BLT) and myofascial release (MFR). Under these different types of manipulation exist many subsets of different techniques that can be described as direct- a forceful engagement of a restrictive/pathologic barrier, indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier, the patient actively assists in the treatment and the patient relaxing, allowing the practitioner to move and balance the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body, including muscles, tendons, ligaments, joints, fascia and viscera. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

(e). Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of new or progressive neurologic deficits.

(f). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to six treatments.

(ii). Frequency: One to two times per week for the first two weeks as indicated by the severity of the condition. Treatment may continue at one treatment per week for the next six weeks.

(iii). Optimum Duration: Eight weeks.

(iv). Maximum Duration: Eight weeks. At week eight, patients should be re-evaluated. Care beyond eight weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at one treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis.

v. Manipulation under General Anesthesia (MUA): refers to manual manipulation of the lumbar spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for their use. There have been no high

quality studies to justify its benefits given the risks of general anesthetic and conscious sedation. It is not recommended.

vi. Manipulation Under Joint Anesthesia (MUJA): refers to manipulation of the lumbar spine in combination with a fluoroscopically guided injection of anesthetic with or without corticosteroid agents into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

vii. Massage—Manual or Mechanical: Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioners' hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range-of-motion, or to increase muscle relaxation and flexibility prior to exercise.

(a). There is good evidence that massage therapy in combination with exercise reduces pain and improves function short-term for patients with subacute low back pain (Cherkin DC 2001; Furlan AD 2008; Preyde, 2010).

(b). Timing/Frequency/Duration

(i). Time to Produce Effect: Immediate.

(ii). Frequency: One to two times per week.

(iii). Optimum Duration: Six weeks.

(iv). Maximum Duration: Eight weeks.

viii. Mobilization (Joint): Is a generally well-accepted treatment. Mobilization is passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. For Level V mobilization contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Six to nine treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

ix. Mobilization (Soft Tissue): Is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Four to nine treatments.

(ii). Frequency: Up to three times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

x. Percutaneous Electrical Nerve Stimulation (PENS): Needles are used to deliver low-voltage electrical current under the skin. Theoretically this therapy prevents pain signals traveling through small nerve fibers from reaching the brain, similar to the theory of TENS. There is good evidence that PENS produces improvement of pain and function compared to placebo; however, there is no evidence that the effect is prolonged after the initial three week treatment episode (Ghonomie, 1999, Hamza 2000). There are no well done studies that show PENS performs better than TENS for chronic pain patients. PENS is more invasive, requires a trained health care provider and has no clear long term effect; therefore it is not generally recommended.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to four treatments.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Nine sessions.

(iv). Maximum Duration: 12 sessions per year.

xi. Superficial Heat and Cold Therapy (Including Infrared Therapy): is a generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Two to five times per week.

(iii). Optimum Duration: Three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months.

(iv). Maximum Duration: Eight weeks.

xii. Traction—Manual: Manual traction is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to three sessions.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Four weeks.

(iv). Maximum Duration: Four weeks.

xiii. Traction—Mechanical: Mechanical traction is indicated for decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. There is some evidence that mechanical traction, using specific, instrumented axial distraction technique, is not more effective than active graded therapy without mechanical traction. Therefore, mechanical traction is not recommended for chronic axial spine pain (Schimmel J 2009).

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: One to three sessions up to 30 minutes. If response is negative after three treatments, discontinue this modality.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Four weeks.

(iv). Maximum Duration: Four weeks.

xiv. Transcutaneous Electrical Nerve Stimulation (TENS): should include least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: Immediate.

(ii). Frequency: Variable.

(iii). Optimum Duration: Three sessions. If beneficial, provide with home unit.

(iv). Maximum Duration: Three sessions. Purchase if effective.

xv. Ultrasound (Including Phonophoresis): is an accepted treatment which uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation. Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

(a). Timing/Frequency/Duration

(i). Time to Produce Effect: 6 to 15 treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Two months.

xvi. Vertebral Axial Decompression (VAX-D)/DRX, 9000: Motorized traction devices which purport to produce non-surgical disc decompression by creating negative intradiscal pressure in the disc space include devices with the trade names of VAX-D and DRX 9000. There are no good studies to support their use. They are not recommended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1692 (June 2011), amended LR 41:

§2113. Therapeutic Procedures—Operative

A. When considering operative intervention in chronic pain management, the treating physician must carefully consider the inherent risk and benefit of the procedure. All operative intervention should be based on a positive correlation with clinical findings, the clinical course, and diagnostic tests. A comprehensive assessment of these factors should have led to a specific diagnosis with positive identification of the pathologic condition. Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions.

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b. fewer restrictions at work or performing activities of daily living;

c. decrease in usage of medications prescribed for the work-related injury;

d. measurable functional gains, such as increased range of motion or documented increase in strength;

e. education of the patient should include the proposed goals of the surgery, expected gains, risks or complications, and alternative treatment.

B. Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician. If a treating physician recommends a specific smoking cessation program peri-operatively, this should be covered by the insurer. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels. The surgeon will make the final determination as to whether smoking cessation is required prior to surgery.

C. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

D. Procedures:

1. Neurostimulation

a. Description: Spinal cord stimulation (SCS) is the delivery of low-voltage electrical stimulation to the spinal cord or peripheral nerves to inhibit or block the sensation of pain. The system uses implanted electrical leads and a battery powered implanted pulse generator.

b. There is some evidence that SCS is superior to reoperation in setting of persistent radicular pain after lumbosacral spine surgery (North R 2005), and there is some evidence that SCS is superior to conventional medical management in the same setting (Kumar K 2008). Success was defined as achieving 50 percent or more pain relief (North R 2005; Kumar K 2008). Some functional gains have been demonstrated (Kemler M 2000; Kumar K 2007; Barolat G 1998, 2001; Frey M 2009). These findings may persist at three years of follow-up in patients who had an excellent initial response and who are highly motivated.

c. It is particularly important that patients meet all of the indications before a permanent neurostimulator is placed because several studies have shown that workers' compensation patients are less likely to gain significant relief than other patients (Hollingworth, 2011). As of the time of this guideline writing, spinal cord stimulation devices have been FDA approved as an aid to in the management of chronic intractable pain of the trunk and/or limbs, including unilateral and bilateral pain associated with the following: failed back surgery syndrome, intractable low back pain and leg pain.

d. Some evidence shows that SCS is superior to reoperation and conventional medical management for severely disabled patients who have failed conventional treatment and have Complex Regional Pain Syndrome (CRPS I) or failed back surgery with persistent radicular neuropathic pain (Kemler 2000; North 2005, Kumar 2008).

e. While there is no evidence demonstrating effectiveness for use of SCS with CRPS II, it is generally accepted that SCS can be used for patients who have this condition. There is no evidence that supports its use for spinal axial pain. SCS may be most effective in patients with CRPS I or II who have not achieved relief with oral medications, rehabilitation therapy, or therapeutic nerve blocks, and in whom the pain has persisted for longer than six months (Kemler M 2000; North R 2005; Kumar K 2008; Barolat G 1998, 2001; Frey M 2009).

f. Particular technical expertise is required to perform this procedure and is available in some neurosurgical, rehabilitation, and anesthesiology training programs and fellowships. Physicians performing this procedure must be trained in neurostimulation implantation and participate in ongoing training workshops on this subject, such as those sponsored by the International Spine Intervention Society (ISIS) or as sponsored by implant manufacturers. Surgical procedures should be performed by surgeons, usually with a neurosurgical or spinal background.

g. Complications: Serious, less common complications include spinal cord compression, paraplegia, epidural hematoma, epidural hemorrhage, undesirable change in stimulation, seroma, CSF leakage, infection, erosion, and allergic response. Other complications consist of dural puncture, hardware malfunction or equipment migration, pain at implantation site, loss of pain relief, chest wall stimulation, and other surgical risks. In recent studies device complication rates have been reported to be 25 percent at six months (Kemler M 2000), 32 percent at 12 months (Kumar K 2007), and 45 percent at 24 months (Kumar K 2008). The most frequent complications are reported to be electrode migration (14 percent) and loss of paresthesia (12 percent) (Kemler 2000; North 2005, Kumar 2008).

h. Surgical Indications: Patients with established CRPS I or II or a failed spinal surgery with persistent functionally limiting radicular pain greater than axial pain who have failed conservative therapy including active and/or passive therapy, pre-stimulator trial psychiatric evaluation and treatment, medication management, and therapeutic injections. SCS is not recommended for patients with the major limiting factor of persistent axial spine pain. SCS may be indicated in a subset of patients who have a clear neuropathic radicular pain (radiculitis). The extremity pain

should account for at least 50 percent or greater of the overall back and leg pain experienced by the patient. Prior authorization is required. Habituation to opioid analgesics in the absence of a history of addictive behavior does not preclude the use of SCS. Patients with severe psychiatric disorders, and issues of secondary gain are not candidates for the procedure (Kemler M 2000). Approximately, one third to one half of patients who qualify for SCS can expect a substantial reduction in pain relief; however, it may not influence allodynia, and hypesthesia (North R 2005; Kemler M 2008; Barolat G 1998, 2001; Frey M 2009). Patients' expectations need to be realistic, and therefore, patients should understand that the SCS intervention is not a cure for their pain but rather a masking of their symptomatology which might regress over time. There appears to be a likely benefit of up to three years (Kemler M 2008). Patients must meet the following criteria in order to be considered candidates for neurostimulation:

i. SCS may be indicated in a subset of patients who have a clear neuropathic radicular pain (radiculitis); are not candidates for surgical intervention on the spine; have burning pain in a distribution amenable to stimulation coverage and have pain at night not relieved by position. The extremity pain should account for at least 50% or greater of the overall leg and back pain experienced by the patient. In cases of complex regional pain syndrome, please refer to the CRPS Medical Treatment Guidelines.

ii. A comprehensive psychiatric or psychological evaluation prior to the stimulator trial has been performed. This evaluation should include a standardized detailed personality inventory with validity scales (such as MMPI-2, MMPI-2-RF, or PAI) pain inventory with validity measures (for example, BHI 2, MBMD); clinical interview and complete review of the medical records. Before proceeding to a spinal stimulator trial the evaluation should find the following:

(a). No indication of falsifying information, or of invalid response on testing; and

(b). No primary psychiatric risk factors or "red flags" (e.g. psychosis, active suicidality, severe depression, or addiction) (Kemler M 2000; Bruns and Disorbio 2009). (Note that tolerance and dependence to opioid analgesics are not addictive behaviors and do not preclude implantation); and

(c). A level of secondary risk factors or "yellow flags" (e.g. moderate depression, job dissatisfaction, dysfunctional pain conditions) judged to be below the threshold for compromising the patient's ability to benefit from neurostimulation (den Boer, et al, 2006; Bruns and Disorbio, 2009; Rosenberger et al. 2006; Block, et al 2001).

(d). The patient is cognitively capable of understanding and operating the neurostimulation control device; and

(e). The patient is cognitively capable of understanding and appreciating the risks and benefits of the procedure and

(f). The patient has demonstrated a history of motivation in and adherence to prescribed treatments.

(g). The psychologist or psychiatrist performing these evaluations should not be an employee of the physician performing the implantation. This evaluation must be completed, with favorable findings, before the screening trial

is scheduled. Significant personality disorders must be taken into account when considering a patient for spinal cord stimulation and other major procedures.

iii. All reasonable surgical and non-surgical treatment has been exhausted; and

iv. The topography of pain and its underlying pathophysiology are amenable to stimulation coverage (the entire painful extremity area has been covered); and

v. A successful neurostimulation screening test of at least three to seven days (North R 2005; Kemler M 2000, 2008).

(a). For a spinal cord neurostimulation screening test, a temporary lead is implanted at the level of pain and attached to an external source to validate therapy effectiveness. A screening test is considered successful if the patient meets both of the following criteria: (a) experiences a 50 percent decrease radicular or CRPS in pain, which may be confirmed by visual analogue scale (VAS) or Numerical Rating Scale (NRS) (Kemler M 2000; North R 2005; Kumar K 2007), and (b) demonstrates objective functional gains or decreased utilization of pain medications (Kemler M 2000; North R 2005; Kumar K 2007). Objective, measurable, functional gains should be evaluated by an occupational therapist and/or physical therapist and the primary treating physician prior to and before discontinuation of the trial.

i. Contraindications:

i. Unsuccessful neurostimulation SCS test – either inability to obtain objective, documented functional improvement or reduction of pain. those with cardiac pacemakers, patient unable to properly operate the system. It should not be used if future MRI is planned.

ii. Those with cardiac pacemakers should be evaluated on an individual basis as some may qualify for surgery (Ooi YC 2011).

iii. Patient who are unable to properly operate the system.

iv. Patients who are anti-coagulated and cannot be without anticoagulation for a few days (e.g. patients with artificial heart valves).

v. Patients with frequent severe infections.

vi. Patients for whom a future MRI of a body part below the head is planned. MRI of the head is permissible with some manufacturers.

j. Operative Treatment: Implantation of stimulating leads connected by extensions to either an implanted neurostimulator or an implanted receiver powered by an external transmitter. The procedure may be performed either as an open or a percutaneous procedure, depending on the presence of epidural fibrosis and the anatomical placement required for optimal efficacy. During the final procedure the patient must be awakened to establish full coverage from the placement of the lead. One of the most common failures is misplaced leads. Functional improvement is anticipated for up to three years or longer when objective functional improvement has been observed during the time of neurostimulation screening exam (Kemler M 2008).

k. Post-operative Considerations: MRI is contraindicated after placement of neurostimulators except for cranial imaging with some models.

l. Post-operative Therapy: Active and/or passive therapy should be employed to improve function. Implantable stimulators will require frequent monitoring

such as adjustment of the unit and replacement of batteries. Estimated battery life of SCS implantable devices is usually 5 to 10 years depending on the manufacturer (Kemler M 2008).

2. Peripheral Nerve Stimulation

a. There are no randomized controlled studies for this treatment. This modality should only be employed with a clear nerve injury or when the majority of pain is clearly in a nerve distribution in patients who have completed six months of other appropriate therapy including pre-trial psychosocial evaluation and treatment.

b. A screening trial should take place over three to seven days and is considered successful if the patient meets both of the following criteria: experiences a 50 percent decrease in pain, which may be confirmed by Visual Analogue Scale (VAS) or Numerical Rating Scale (NRS); and demonstrates objective functional gains or decreased utilization of pain medications. Objective, measurable, functional gains should be evaluated by an occupational therapist and/or physical therapist and the primary treating physician prior to and before discontinuation of the trial. It may be used for proven occipital, ulnar, median and other isolated nerve injuries (Van Calenbergh F 2009; Mekhail N 2010; Cruccu G 2007; Frey M 2009).

3. Intrathecal Drug Delivery

a. Not generally recommended. Requires prior authorization. Due to conflicting studies in this population and complication rate for long-term use, it may be considered only in very rare occasions when dystonia and spasticity are dominant features or when pain is not able to be managed using any other non-operative treatment. Specific brands of infusion systems have been FDA approved for the following: chronic intraspinal (epidural and intrathecal) infusion of preservative-free morphine sulfate sterile solution in the treatment of chronic intractable pain, chronic infusion of preservative-free ziconotide sterile solution for the management of severe chronic pain, and chronic intrathecal infusion of baclofen for the management of severe spasticity.

b. Description: This mode of therapy delivers small doses of medications directly into the cerebrospinal fluid.

c. Complications: Intrathecal delivery is associated with significant complications, such as infection, catheter disconnects, CSF leak, arachnoiditis, pump failure, nerve injury, and paralysis.

d. Typical adverse events reported with opioids (ie, respiratory depression, tolerance, and dependence), or spinal catheter-tip granulomas that might arise during intrathecal morphine or hydromorphone treatment have not currently been recorded for ziconotide. The most common presentation of an intraspinal mass is a sudden increase in dosage required for pain relief, with new neurologic defects secondary to a mass effect (Miele 2006). Technical errors can lead to drug overdose which can be life-threatening (Johnson 2011).

e. Surveys have shown technical problems requiring surgical correction in 18 percent to 40 percent of patients (Gerber 2003, Turner 2007). CSF leakage may occur with multiple dural punctures. Since the needle is larger than the spinal catheter, there may be incomplete tissue sealing around the catheter (Gerber 2003). The function of the pump depends on its electronic power source,

which may be disrupted by the magnet of an MRI; therefore, after the patient has an MRI, the pump should be checked to ensure that it does not need to be restarted (Staats 2008). The delivery rate can be affected by atmospheric pressure and body temperature (Ghafoor, 2007).

f. Indications: Clinical studies are conflicting, regarding long-term, effective pain relief in patients with non-malignant pain. The OWCA does not generally recommend the use of intrathecal drug delivery systems in injured workers with chronic pain. Due to the complication rate for long-term use, it may be considered only in very rare occasions when dystonia and spasticity are dominant features or when pain is not able to be managed using any other non-operative treatment. This treatment must be prior authorized and have the recommendation of at least one physician experienced in chronic pain management in consultation with the primary treating physician.

g. Surgical Indications: The procedure should be performed by physicians with documented experience. This small eligible sub-group of patients must meet all of the following indications:

i. A diagnosis of a specific physical condition known to be chronically painful has been made on the basis of objective findings; and

ii. All reasonable surgical and non-surgical treatment has been exhausted including failure of conservative therapy including active and/or passive therapy, medication management, or therapeutic injections; and

iii. Pre-trial psychiatric or psychological evaluation has been performed (as for SCS) and has demonstrated motivation and long-term commitment without issues of secondary gain. Significant personality disorders must be taken into account when considering a patient for spinal cord stimulation and other major procedures; and

iv. There is no evidence of current addictive behavior. (Tolerance and dependence to opioid analgesics are not addictive behaviors and do not preclude implantation); and

v. A successful trial of continuous infusion by a percutaneous spinal infusion pump for a minimum of 24 hours. A screening test is considered successful if the patient experiences a 50 percent decrease in pain, which may be confirmed by VAS, and demonstrates objective functional gains or decreased utilization of pain medications. Functional gains should be evaluated by an occupational therapist and/or physical therapist prior to and before discontinuation of the trial.

h. Contraindications: Infection, body size insufficient to support the size and weight of the implanted device. Patients with other implanted programmable devices should be given these pumps with caution since interference between devices may cause unintended changes in infusion rates.

4. Neuroablation with Rhizotomy. Neuroablation or neuro-destructive procedures are not commonly used in the management of non-malignant pain. These techniques require specific expertise to perform, have erratic results, and high rates of complication. Therefore, the OWCA does not recommend the use of neuroablative procedures, except rhizotomy, for injured workers with chronic pain.

5. Dorsal Nerve Root Resection. This procedure is not recommended. There exists the possibility of complications

including unintended extensive nerve damage causing significant motor or sensibility changes from larger than anticipated lesioning of the ganglia at the dorsal ganglia level (North R 1991). For radio-frequency ablation refer to Therapeutic Procedures, Non-operative, Dorsal Root Ganglion Radiofrequency Ablation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1711 (June 2011), amended LR 41:

§2115. Maintenance Management

A. Successful management of chronic pain conditions results in fewer relapses requiring intense medical care. Failure to address long-term management as part of the overall treatment program may lead to higher costs and greater dependence on the health care system. Management of CPD continues after the patient has met the definition of maximum medical improvement (MMI). MMI is declared when a patient's condition has plateaued and the authorized treating physician believes no further medical intervention is likely to result in improved function. When the patient has reached MMI, a physician must describe in detail the maintenance treatment.

B. Maintenance care in CPD requires a close working relationship between the carrier, the providers, and the patient. Providers and patients have an obligation to design a cost-effective, medically appropriate program that is predictable and allows the carrier to set aside appropriate reserves. Carriers and adjusters have an obligation to assure that medical providers can design medically appropriate programs. A designated primary physician for maintenance team management is recommended.

C. Maintenance care will be based on principles of patient self-management. When developing a maintenance plan of care, the patient, physician and insurer should attempt to meet the following goals:

1. Maximal independence will be achieved through the use of home exercise programs or exercise programs requiring special facilities (e.g., pool, health club) and educational programs;

2. Modalities will emphasize self-management and self-applied treatment;

3. Management of pain or injury exacerbations will emphasize initiation of active therapy techniques and may occasionally require anesthetic injection blocks.

4. Dependence on treatment provided by practitioners other than the authorized treating physician will be minimized;

5. Periodic reassessment of the patient's condition will occur as appropriate;

6. Patients will understand that failure to comply with the elements of the self-management program or therapeutic plan of care may affect consideration of other interventions.

D. The following are Specific Maintenance Interventions and Parameters:

1. Home Exercises Programs and Equipment. Most patients have the ability to participate in a home exercise program after completion of a supervised exercise rehabilitation program. Programs should incorporate an exercise prescription including the continuation of an age-adjusted and diagnosis-specific program for aerobic

conditioning, flexibility, stabilization, and strength. Some patients may benefit from the purchase or rental of equipment to maintain a home exercise program. Determination for the need of home equipment should be based on medical necessity to maintain MMI, compliance with an independent exercise program, and reasonable cost. Before the purchase or long-term rental of equipment, the patient should be able to demonstrate the proper use and effectiveness of the equipment. Effectiveness of equipment should be evaluated on its ability to improve or maintain functional areas related to activities of daily living or work activity. Home exercise programs are most effective when done three to five times a week. Prior to purchasing the equipment a therapist and/or exercise specialist who has treated the patient should visit a facility with the patient to assure proper use of the equipment. Occasionally, compliance evaluations may be made through a four week membership at a facility offering similar equipment.

2. Exercise Programs Requiring Special Facilities: Some patients may have higher compliance with an independent exercise program at a health club versus participation in a home program. All exercise programs completed through a health club facility should focus on the same parameters of an age-adjusted and diagnosis-specific program for aerobic conditioning, flexibility, stabilization, and strength. Prior to purchasing a membership, a therapist and/or exercise specialist who has treated the patient should visit a facility with the patient to assure proper use of the equipment. Selection of health club facilities should be limited to those able to track attendance and utilization, and provide records available for physician and insurer review.

a. Timing/Frequency/Duration

i. Frequency: Two to three times per week

ii. Maximum Maintenance Duration: Eight weeks.

Continuation beyond eight weeks should be based on functional benefit and patient compliance. Health club membership should not extend beyond eight weeks if attendance drops below two times per week on a regular basis.

3. Patient Education Management: Educational classes, sessions, or programs may be necessary to reinforce self-management techniques. This may be performed as formal or informal programs, either group or individual.

a. Timing/Frequency/Duration

i. Maintenance Duration: Two to six educational visits during one 12-month period.

4. Psychological Management: An ideal maintenance program will emphasize management options implemented in the following order:

a. individual self-management (pain control, relaxation and stress management, etc.);

b. group counseling;

c. individual counseling by a psychologist or psychiatrist; and

d. inpatient treatment. Exacerbation of the injury may require psychological treatment to restore the patient to baseline. In those cases, use treatments and timeframe parameters listed in the Biofeedback and Psychological Evaluation or Intervention sections.

e. Timing/Frequency/Duration

i. Maintenance Duration: 6 to 10 visits during the first year and four to six visits per year thereafter. In cases of

significant exacerbation, refer to the psychological treatment section in Therapeutic Procedures, Non-operative.

5. Non-Opioid Medication Management: In some cases, self-management of pain and injury exacerbations can be handled with medications, such as those listed in the Medication section. Physicians must follow patients who are on any chronic medication or prescription regimen for efficacy and side effects. Laboratory or other testing may be appropriate to monitor medication effects on organ function.

a. Timing/Frequency/Duration

i. Maintenance Duration: Usually, four medication reviews within a 12 month period. Frequency depends on the medications prescribed. Laboratory and other monitoring as appropriate.

6. Opioid Medication Management: As compared with other painful conditions, there may be a role for chronic augmentation of the maintenance program with opioid medications. In selected cases, scheduled medications may prove to be the most cost effective means of insuring the highest function and quality of life; however, inappropriate selection of these patients may result in a high degree of iatrogenic illness. A patient should have met the criteria in the opioids section of these guidelines before beginning maintenance opioids. Laboratory or other testing may be appropriate to monitor medication effects on organ function. The following management is suggested for maintenance opioids:

a. The medications should be clearly linked to improvement of function, not just pain control. All follow-up visits should document the patient's ability to perform routine functions satisfactorily. Examples include the abilities to perform: work tasks, drive safely, pay bills or perform basic math operations, remain alert and upright for 10 hours per day, or participate in normal family and social activities. If the patient is not maintaining reasonable levels of activity the patient should usually be tapered from the opioid and tried on a different long-acting opioid.

b. A low dose opioid medication regimen should be defined, which may minimally increase or decrease over time. Dosages will need to be adjusted based on side effects of the medication and objective function of the patient. A patient may frequently be maintained on additional non-opioid medications to control side effects, treat mood disorders, or control neuropathic pain; however, only one long-acting opioid and one short-acting opioid for rescue use should be prescribed in most cases. Buccally absorbed opioids are not appropriate for these non-malignant pain patients. Transdermal medications are generally not recommended.

c. All patients on chronic opioid medication dosages need to sign an appropriate opioid contract with their physician for prescribing the opioids.

d. The patient must understand that continuation of the medication is contingent on their cooperation with the maintenance program. Use of non-prescribed drugs may result in tapering of the medication. The clinician should order random drug testing at least annually and when deemed appropriate to monitor medication compliance.

e. Patients on chronic opioid medication dosages must receive them through one prescribing physician.

f. Timing/Frequency/Duration

i. Maintenance Duration: Up to 12 visits within a 12-month period to review the opioid plan. Laboratory and other monitoring as appropriate.

7. Therapy Management: Some treatment may be helpful on a continued basis during maintenance care if the therapy maintains objective function and decreases medication use. With good management, exacerbations should be uncommon; not exceeding two times per year and using minimal or no treatment modality beyond self-management. On occasion, exacerbated conditions may warrant durations of treatment beyond those listed below. Having specific goals with objectively measured functional improvement during treatment can support extended durations of care. It is recommended that if after six to eight visits no treatment effect is observed, alternative treatment interventions should be pursued.

a. Timing/Frequency/Duration

i. Active Therapy, Acupuncture, or Manipulation Maintenance Duration: 10 visits [for each treatment] during the first year and then decreased to five visits per year thereafter.

8. Injection Therapy

a. Trigger Point Injections - These injections may occasionally be necessary to maintain function in those with myofascial problems.

i. Timing/Frequency/Duration

(a). Maintenance Duration: Not more than four injections per session not to exceed four sessions per 12-month period.

b. Epidural and Selective Nerve Root Injections - Patients who have experienced functional benefits from these injections in the past may require injection for exacerbations of the condition.

i. Timing/Frequency/Duration

(a). Maintenance Duration: Two to four injections per 12-month period.

9. Purchase or Rental of Durable Medical Equipment

a. It is recognized that some patients may require ongoing use of self-directed modalities for the purpose of maintaining function and/or analgesic effect. Purchase or rental of modality based equipment should be done only if the assessment by the physician and/or therapist has determined the effectiveness, compliance, and improved or maintained function by its application. It is generally felt that large expense purchases such as spas, whirlpools, and special mattresses are not necessary to maintain function.

i. Timing/Frequency/Duration

(a). Maintenance Duration: Not to exceed three months for rental equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1713 (June 2011).

Subchapter B. Complex Regional Pain Syndrome §2119. General Guidelines Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. ...

2. **Minimal Information for Request of Authorization.** The minimum submission by a health care provider must include a current history and physical examination. As used herein, "current" means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. **Education.** Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. **Informed Decision Making.** Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. **Treatment Parameter Duration.** Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. **Active Interventions.** Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive

interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. **Active Therapeutic Exercise Program.** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. **Positive Patient Response.** Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. **Re-Evaluation of Treatment Every Three to Four Weeks.** If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. **Surgical Interventions.** Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. **Pharmacy-Louisiana Law and Regulation.** All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1716 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1157 (June 2014), LR 41:

Chapter 22. Neurological and Neuromuscular Disorder Medical Treatment Guidelines
Subchapter A. Carpal Tunnel Syndrome (CTS) Medical Treatment Guidelines

§2203. General Guidelines Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers’ Compensation guidelines and critical to the reader’s application of the guidelines in this document.

1. ...

2. Minimal Information for Request of Authorization. The minimum submission by a health care provider must include a current history and physical examination. As used herein, “current” means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers’ compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual’s identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making

and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand

the length of partial and full disability expected post-operatively.

11. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based

on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a.- B...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1736 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1158 (June 2014), LR 41:

§2205. Definitions

A. Carpal tunnel syndrome (CTS) is one of the most common mononeuropathies (a disorder involving only a single nerve). The median nerve is vulnerable to compression and injury in the region of the wrist and palm. In this area, the nerve is bounded by the wrist bones and the transverse carpal ligament. The most common site of compression is at the proximal edge of the flexor retinaculum (an area near the crease of the wrist). There is often a myofascial component in the patient's presentation. This should be considered when proceeding with the diagnostic workup and therapeutic intervention.

B. Studies have repeatedly confirmed that the diagnosis cannot be made based on any single historical factor or physical examination finding. There are no individual provocative testing with strong sensitivity and specificity. Additionally, electrodiagnostic testing may be positive in asymptomatic individuals. The diagnosis of CTS, therefore, remains a clinical diagnosis based on a preponderance of supportive findings.

C. Classic findings of CTS include subjective numbness or dysesthesias confined to the median nerve distribution, worsening of symptoms at night, dropping of objects, and positive exam findings. When the diagnosis is in question, steroid injection into the carpal tunnel is a strongly supportive test if it is followed by significant relief of symptoms.

1. Please refer to other appropriate upper extremity guidelines as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1738 (June 2011), amended LR 41:

§2209. Follow-Up Diagnostic Testing Procedures

A - A.9.b.iii. ...

B. Imaging Studies

1. Radiographic Imaging. Not generally required for most CTS diagnoses; recommended for patients with documented joint crepitation or loss of hand or wrist motion. However, it may be necessary to rule out other pathology in the cervical spine, shoulder, elbow, wrist or hand. Wrist and elbow radiographs would detect degenerative joint disease, particularly scapholunate dissociation and thumb

carpometacarpal abnormalities which occasionally occur with CTS.

B.2. - D.1.d.iv.(a). ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1740 (June 2011), amended LR 41:

§2211. Therapeutic Procedures—Non-Operative

A. - E. ...

F. In cases where a patient has a specific medical indication that prevents attending an outpatient center, home therapy may be necessary. Home therapy may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone. Home therapy is usually of short duration and continues until the patient is able to tolerate coming to an outpatient center.

G...

H. The following procedures are listed in alphabetical order.

1. Injections-Therapeutic.

a. Steroids Injections. Beneficial effects of injections are well-established, but generally considered to be temporary. Recurrence of symptoms is frequent. It is not clear whether or not injections slow progression of electrodiagnostic changes. Therefore, although symptoms may be temporarily improved, nerve damage may be progressing. When motor changes are present, surgery is preferred over injections. Injections may be given for confirmation of Carpal Tunnel Syndrome Diagnosis.

i. Time to Produce Effect: two to five days

ii. Frequency: every six to eight weeks

iii. Optimum number: two injections with documented positive gain and functional improvement after first injection.

b. If following the first injection, symptomatic relief is followed by recurrent symptoms, the decision to perform a second injection must be weighed against alternative treatments such as surgery. Surgery may give more definitive relief of symptoms.

2. Job Site Modification. Early evaluation and training of body mechanics and other ergonomic factors are essential for every injured worker and should be done by a qualified individual. In some cases, this requires a job site evaluation. Some evidence supports alteration of the job site in the early treatment of Carpal Tunnel Syndrome (CTS). There is no single factor or combination of factors that is proven to prevent or ameliorate CTS, but a combination of ergonomic and psychosocial factors is generally considered to be important. Physical factors that may be considered include use of force, repetition, awkward positions, upper extremity vibration, cold environment, and contact pressure on the carpal tunnel. Psychosocial factors to be considered include pacing, degree of control over job duties, perception of job stress, and supervisory support. The job analysis and modification should include input from the employee, employer, and ergonomist or other professional familiar with work place evaluation. The employee must be observed performing all job functions in order for the job site analysis to be valid. Periodic follow-up is recommended to evaluate effectiveness of the intervention and need for additional ergonomic changes.

a. Ergonomic changes should be made to modify the potential hazards identified at the job site. In addition workers should be counseled to vary tasks throughout the day whenever possible. Occupational Safety and Health Administration (OSHA) suggests that workers who perform high repetition tasks, or jobs that require long periods of static posture, including keyboarding. Mini breaks should include standing, stretching, and moving around.

b. ...

c. Seating Description/Work Station Components. Reference to current OSHA guidelines for seating and work station recommendations should always be considered. The following description may aid in evaluating seated work positions: The head should incline only slightly forward, and if a monitor is used, there should be 20 – 40 inches of viewing distance with no glare. Arms should rest naturally, with forearms parallel to the floor, elbows at the sides, and wrists straight or minimally extended. The back must be properly supported by a chair, which allows change in position and backrest adjustment. There must be good knee and legroom, with the feet resting comfortably on the floor or footrest. Tools should be within easy reach, and twisting or bending should be avoided.

d. ...

Type of Job Duty	Hours per Day
Pinching an unsupported object(s) weighing 2 lbs or more per hand, or pinching with a force of 4 lbs or more per hand (comparable to pinching a half a ream of paper): Highly repetitive motion Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 3 hours total/day ----- More than 4 hours total/day
Gripping an unsupported object(s) weighing 10 lbs or more/hand, or gripping with a force of 10 lbs or more/hand (comparable to clamping light duty automotive jumper cables onto a battery): *Handles should be rounded and soft, with at least 1-2.5" in diameter grips at least 5" long. Highly repetitive motion Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 3 hours total/day ----- More than 4 hours total/day
Repetitive Motion (using the same motion with little or no variation every few seconds), excluding keying activities: High, forceful exertions with the hands, with palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 2 hours total/day ----- More than 6 hours total/day
Intensive Keying: Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 4 hours total/day ----- More than 7 hours total/day
Repeated Impact: Using the hand (heel/base of palm) as a hammer more than once/minute	More than 2 hours total/day

Type of Job Duty	Hours per Day
Vibration: Two determinants of the tolerability of segmental vibration of the hand are the frequency and the acceleration of the motion of the vibrating tool, with lower frequencies being more poorly tolerated at a given level of imposed acceleration, expressed below in multiples of the acceleration due to gravity (10m/sec/sec). Frequency range 8-15 Hz and acceleration 6 g Frequency range 80 Hz and acceleration 40 g Frequency range 250 Hz and acceleration 250 g ----- Frequency range 8-15 Hz and acceleration 1.5 g Frequency range 80 Hz and acceleration 6 g Frequency range 250 Hz and acceleration 20 g	More than 30 minutes at a time ----- More than 4 hours at a time

3. Medications including nonsteroidal anti-inflammatory medications (NSAIDs), oral steroids, diuretics, and pyridoxine (Vitamin B6) have not been shown to have significant long-term beneficial effect in treating Carpal Tunnel Syndrome. Although NSAIDs are not curative, they and other analgesics may provide symptomatic relief. All narcotics and habituating medications should be prescribed with strict time, quantity, and duration guidelines with a definite cessation parameter. Prescribing these drugs on an as needed basis (PRN) should almost always be avoided.

a. Medication use in the treatment of Carpal Tunnel Syndrome is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from initial symptoms to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically.

b. Vitamin B6: Randomized trials have demonstrated conflicting results. Higher doses may result in development of a toxic peripheral neuropathy. In the absence of definitive literature showing a beneficial effect, use of Vitamin B6 cannot be recommended.

c. Oral Steroids: have been shown to have short-term symptomatic benefit but no long-term functional benefit and are not recommended due to possible side effects.

4. Occupational Rehabilitation Programs

a. Non-Interdisciplinary. These programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to achieve treatment and/or simulated/real work.

i. Work Conditioning. These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to

modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good. Work conditioning programs may include some components of work simulation.

- (a). Length of visit: one to two hours per day
- (b). Frequency: two to five visits per week
- (c). Optimum Duration: two to four weeks
- (d). Maximum Duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. ...

- (a). Length of visit: two to six hours per day
- (b). Frequency: two to five visits per week
- (c). Optimum Duration: two to four weeks
- (d). Maximum Duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

b. - b.i. ...

ii. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation, team physicians having experience in occupational rehabilitation, occupational therapy, physical therapy, case manager, and psychologist. As appropriate, the team may also include: chiropractor, RN, or vocational specialist.

- (a). Length of visit: Up to eight hours/day
- (b). Frequency: two to five visits per week
- (c). Optimum Duration: two to four weeks
- (d). Maximum Duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

5. Orthotics/Immobilization with Splinting is a generally accepted, well-established and widely used therapeutic procedure. There is some evidence that splinting leads to more improvement in symptoms and hand function than watchful waiting alone. Because of limited patient compliance with day and night splinting in published studies, evidence of effectiveness is limited to nocturnal splinting alone. Splints should be loose and soft enough to maintain comfort while supporting the wrist in a relatively neutral position. This can be accomplished using a soft or rigid splint with a metal or plastic support. Splint comfort is critical and may affect compliance. Although off-the-shelf splints are usually sufficient, custom thermoplastic splints may provide better fit for certain patients.

a. ...

b. Splinting is generally effective for milder cases of CTS. Long-term benefit has not been established. An effect should be seen in two - four weeks.

i. Time to Produce Effect: one-four weeks. If, after four weeks, the patient has partial improvement, continue to follow since neuropathy may worsen, even in the face of diminished symptoms.

ii. Frequency: Nightly. Daytime intermittent, depending on symptoms and activities

iii. Optimum Duration: four to eight weeks

iv. Maximum Duration: two to four months. If symptoms persist, consideration should be given to either repeating electrodiagnostic studies or to more aggressive treatment.

6. Patient Education

a. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed.

i. Time to Produce Effect: Varies with individual patient

ii. Frequency: Should occur at every visit

7. Personality/ Psychological/ Psychiatric/ Psychosocial Intervention is generally accepted, widely used and well established. This group of therapeutic and diagnostic modalities includes, but is not limited to, individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis and meditation. Any screening or diagnostic workup should clarify and distinguish between preexisting versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. This can be used alone or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the Chronic Pain Disorder Medical Treatment Guidelines.

a. Time to Produce Effect: two to four weeks

b. Frequency: one to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly.

c. Optimum Duration: six weeks to three months

d. Maximum Duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required and if further counseling beyond three months is indicated, documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every four to six weeks during treatment.

8. Restriction of Activities. Continuation of normal daily activities is the recommendation for acute and chronic pain without neurologic symptoms. There is good evidence against the use of bed rest in cases without neurologic symptoms. Bed rest may lead to de-conditioning and impair rehabilitation. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with Carpal Tunnel Syndrome. Modified return-to-work with restriction of the activities aggravating the symptomology or that require prolonged gripping and pinching should be considered.

9. Return to Work. Early return-to-work should be a prime goal in treating Carpal Tunnel Syndrome given the poor prognosis for the injured employee who is out of work for more than six months. The employee and employer should be educated in the benefits of early return-to-work. When attempting to return an employee with CTS to the workplace, clear, objective physical restrictions that apply to both work and non-work related activities should be specified by the provider. Good communication between the provider, employee, and employer is essential. Return-to-work is any work or duty that the employee can safely perform, which may not be the worker's regular job activities. Due to the large variety of jobs and the spectrum of severity of CTS, it is not possible for the OWCA to make specific return-to-work guidelines, but the following general approach is recommended:

a. - c. ...

10. Therapy - Active

a. Active therapies are based on the philosophy that therapeutic exercises and/or activities are beneficial for restoring flexibility, strength, endurance, function, range of motion, and alleviating discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task, and thus assists in developing skills promoting independence to allow self-care to continue after discharge. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). At times a provider may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient.

b. - c.iii. ...

11. Therapy-Passive. Therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used in adjunct with active therapies. They may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment. Diathermies have not been shown to be beneficial to patients with CTS and may interfere with nerve conduction.

a. ...

- i. Time to Produce Effect: two-six treatments
- ii. Frequency: one-three times/week, decreasing over time
- iii. Optimum Duration: four-six weeks
- iv. Maximum Duration: eight-ten weeks

b. Ultrasound: There is some evidence that ultrasound may be effective in symptom relief and in improving nerve conduction in mild to moderate cases of CTS. No studies have demonstrated long-term functional benefit. It may be used in conjunction with an active therapy program for non-surgical patients who do not improve with splinting and activity modification. It is not known if there are any long-term deleterious neurological effects from ultrasound.

c. Microcurrent TENS: There is insufficient evidence to support the application of microamperage TENS.

i. Other Passive Therapy: For associated myofascial symptoms, please refer to the Cumulative Trauma Disorder guideline.

12. Vocational Rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification highest functional level, motivation, and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1743 (June 2011), amended LR 41:

§2213. Therapeutic Procedures—Operative

A. Surgical Decompression is well-established, generally accepted, and widely used and includes open and endoscopic techniques. There is good evidence that surgery is more effective than splinting in producing long-term symptom relief and normalization of median nerve conduction velocity. Referral to a surgeon for evaluation should be made if no positive response to treatment is noted after six weeks.

1. Surgical Technique

a. Endoscopic Techniques have had a higher incidence of serious complications (up to 5 percent) compared to open techniques (less than 1 percent). The most commonly seen serious complications are incomplete transection of the transverse carpal ligament and inadvertent nerve or vessel injuries. The incidence of complications may be lower for surgeons who have extensive experience and familiarity with certain endoscopic techniques.

b. Minimal incision release was favored over open release in symptom severity, functional status, and scar tenderness and was favored over to endoscopic release in pain measures at two and four weeks according to Level 1 studies.

c. Choice of technique should be left to the discretion of the surgeon.

A.2. - D.2. ...

E. Post-Operative Treatment

1. Considerations for post-operative therapy are:

a. Immobilization: There is strong evidence showing that immediate immobilization of the wrist following surgery is not necessary and may delay the return to normal activities. Final decisions regarding the need for splinting post-operatively should be left to the discretion of the treating physician based upon his/her understanding of the surgical technique used and the specific conditions of the patient.

b. Home Program: It is generally accepted that all patients should receive a home therapy protocol involving stretching, ROM, scar care, and light resistive exercises. Patients should be encouraged to use the hand as much as possible for daily activities, allowing pain to guide their activities.

c. Supervised Therapy Program: may be helpful in patients who do not show functional improvements post-operatively, have excessive swelling, scar hypersensitivity or pillar pain, significantly limited motion, or in patients with heavy or repetitive job activities. The therapy program may include evaluation and treatment of the generally accepted elements of soft tissue healing and return to function:

i. Soft tissue healing/remodeling: May be used after the incision has healed. It may include soft tissue mobilization / manual technique, scar compression pad, heat/cold application, splinting and/or edema control. wound healing, ultrasound and iontophoresis with Sodium Chloride (NaCl) may be considered for soft tissue remodeling. Diathermy is a non-acceptable adjunct.

- (a). Time to Produce Effect: two-four weeks
- (b). Frequency: one-three times/week
- (c). Optimum Duration: four-six weeks
- (d). Maximum Duration: eight weeks

ii. Return to function:

- (a). Time to Produce Effect: two-four weeks
- (b). Frequency: one -three times/week
- (c). Optimum Duration: four-six weeks
- (d). Maximum Duration: eight weeks

d. Work conditioning/simulation/hardening: These programs may be necessary in the post-operative management of patients who have been out of work for an unusually extended period or may be returning to a different position. Refer to the evaluations in §2209.D.2 and Rehabilitative care outlined in §2211.I.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1748 (June 2011).

Subchapter B. Thoracic Outlet Syndrome

§2217. General Guidelines Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. ...

2. Minimal Information for Request of Authorization. The minimum submission by a health care provider must include a current history and physical examination. As used herein, "current" means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment

of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing

positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. **Surgical Interventions.** Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of “cure” with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. **Pharmacy-Louisiana Law and Regulation.** All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. **Six Month-Time Frame.** The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. **Return To Work.** Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual

chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. **Delayed Recovery.** Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. **Guideline Recommendations and Inclusion of Medical Evidence.** Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1750 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1159 (June 2014).

Chapter 23. Upper and Lower Extremities Medical Treatment Guidelines

Subchapter A. Lower Extremities

§2303. General Guidelines Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers’ Compensation guidelines and critical to the reader’s application of the guidelines in this document.

1. ...

2. **Minimal Information for Request of Authorization.** The minimum submission by a health care provider must include a current history and physical examination. As used herein, “current” means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records

shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers' compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

10. Surgical Interventions. Surgery should be contemplated within the context of expected improvement of functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions. The decision and recommendation for operative treatment, and the appropriate informed consent should be made by the operating surgeon. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

11. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

12. Six Month-Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month timeframe, whenever possible. It is important to note that timeframes may be less pertinent to injuries that do not involve work-time loss or are not occupationally related.

13. Return To Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations. If a practitioner releases a patient at a level of function lower than their previous job position, the practitioner must provide physical limitations and abilities and job modifications. A patient should never be released to simply “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, climbing ladders, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or if necessary, including, but not limited to: a healthcare professional with experience in ergonomics, an occupational health nurse, physical therapist, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

14. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that, even despite optimal care, 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1765 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1160 (June 2014), LR 41:

Chapter 23. Upper and Lower Extremities Medical Treatment Guidelines

Subchapter B. Shoulder Injury Medical Treatment Guidelines

§2317. General Guidelines Principles

A. The principles summarized in this section are key to the intended implementation of all Office of Workers’ Compensation guidelines and critical to the reader’s application of the guidelines in this document.

1. ...

2. Minimal Information for Request of Authorization. The minimum submission by a health care provider must include a current history and physical examination. As used herein, “current” means no more than 45 days prior to the date on which the LWC-WC-1010 form requesting treatment was submitted. Each section of the medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. At each clinical evaluation by the provider, clinical records shall document specific detailed information related to the specific services requested for treatment, and include: current history provided to the level of the condition; current physical findings relevant to the diagnostic testing or additional treatment being requested; current clinical test results; documentation of functional improvements from any prior treatment; current diagnosis, assessment, or impression; and current treatment plan, including services being requested along with the proposed frequency and duration.

3. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of workers’ compensation injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

4. Informed Decision Making. Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual’s identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, occupational therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

5. Treatment Parameter Duration. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

6. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

7. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

8. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to: positional tolerances, range-of-motion (ROM), strength, endurance, activities of daily living, ability to function at work, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

9. Re-Evaluation of Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

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11. Pharmacy-Louisiana Law and Regulation. All prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to: Louisiana State Board of Medical Examiners regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana.

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15. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations.

When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply to the strength of recommendation.

Strong	Level 1 Evidence	We Recommend
Moderate	Level 2 and Level 3 Evidence	We Suggest
Weak	Level 4 Evidence	Treatment is an Option
Inconclusive	Evidence is Either Insufficient or Conflicting	

A.15.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1821 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1162 (June 2014), LR 41:

Family Impact Statement

This amendment to Title 40 should have no impact on families.

Poverty Impact Statement

This amendment to Title 40 should have no impact on poverty or family income.

Provider Impact Statement

1. This Rule should have no impact on the staffing level of the Office of Workers' Compensation as adequate staff already exists to handle the procedural changes.

2. This Rule should create no additional cost to providers or payers.

3. This Rule should have no impact on ability of the provider to provide the same level of service that it currently provides.

Public Comments

All interested persons are invited to submit written comments on the proposed Rule. Such comments should be sent to Patrick Robinson, OWC-Administration, 1001 North 23rd Street, Baton Rouge, LA 70802. Such comments should be received on October 9, 2015, by COB.

Public Hearing

A public hearing will be held on October 28, 2015, at 9:30 a.m. at the Office of Workers' Compensation located at 1001 North 23rd Street at the main campus of the Workforce Commission, in Baton Rouge, LA. The public is invited to attend.

Curt Eysink
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Medical Treatment Guidelines

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule amend Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapters 20-23, to add "Informed Decision Making" to the general guideline principles for cervical spine injuries, low back pain, chronic pain disorder, complex regional pain syndrome, carpal tunnel syndrome, thoracic outlet syndrome, lower extremities, and shoulder injuries, and to update treatment guidelines for carpal tunnel syndrome. In addition, the proposed rule implement the requirements of La. R.S. 23:1203.1, that the Office of Workers' Compensation Administration (OWCA) director, with the assistance of the medical advisory council, review and update the medical treatment schedule at a minimum of once every two years. The proposed rule updates the medical guidelines in accordance with statute.

Besides the cost to publish in the *Louisiana Register*, the proposed rules will not require any expenditure by the OWCA nor will the proposed rules result in any savings to OWCA. Likewise, it is not anticipated that the proposed rules will result in any costs or savings to other state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The implementation of this proposed rule will have no anticipated effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule updates the general guideline principals for medical treatment of injured workers, and updates specific guidelines concerning treatment of carpal tunnel syndrome. It is not anticipated that the proposed rule will produce a direct economic benefit to injured workers. It is anticipated that the proposed rule will provide an indirect benefit to injured workers, employers, and insurers, by providing better medical treatment to injured workers, thus facilitating their recovery and return to work.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated direct effect on competition and employment. It is anticipated that the proposed rules will improve the medical treatment of injured workers and facilitate their return to the workforce.

Patrick Robinson
Director
1509#090

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

Potpourri

POTPOURRI

Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences

Supplement to Annual Quarantine Listing for 2015
Sweetpotato Weevil (LAC 7:XV.Chapter 1)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., R.S. 3:1652, R.S. 3:1732 and LAC 7:XV:107, 109 the annual quarantine listing for 2015 is being supplemented to add the following quarantines and locations.

1.0 Sweetpotato Weevil (*Cylas formicarius elegantulus* Sum)

- (a). ...
- (b). In the State of Louisiana:
 - 1). ...
 - 2). The properties located at the following coordinates: 32.457650, -91.572820; and any properties within a 300-yard radius of these coordinates have been added to the Sweetpotato Weevil Quarantine Listing.

Mike Strain DVM
Commissioner

1509#027

POTPOURRI

Office of the Governor Coastal Protection and Restoration Authority

Deepwater Horizon Oil Spill—Draft Programmatic Damage
Assessment and Restoration Plan and Programmatic
Environmental Impact Statement

ACTION

Notice of Availability of Draft Plan

SUMMARY

In accordance with the Oil Pollution Act of 1990 (OPA) and the National Environmental Policy Act (NEPA), the Federal and State *Deepwater Horizon* Oil Spill natural resource trustee agencies for Louisiana, Mississippi, Alabama, Texas, and Florida (Trustees) are preparing a Draft Programmatic Damage Assessment and Restoration Plan and Programmatic Environmental Impact Statement (PDARP/PEIS). The Draft PDARP/PEIS will include an assessment of the Trustees' natural resources, ecological services, and recreational use services that were injured or lost as a result of the *Deepwater Horizon* Oil Spill (DWH Oil Spill), which occurred on or about April 20, 2010, in the Gulf of Mexico, and a discussion of programmatic alternatives to restore these natural resources. The Trustees are developing restoration alternatives, comprised of various restoration types, to utilize funds provided to address injuries to natural resources and resource services resulting from the DWH Oil Spill. Criteria and evaluation standards under the OPA natural resource damage assessment regulations are

guiding the Trustees' consideration of programmatic restoration alternatives. The Draft PDARP/PEIS will evaluate these programmatic restoration alternatives under criteria set forth in the OPA natural resource damage assessment regulations. The Draft PDARP/PEIS will also evaluate the environmental consequences of the programmatic restoration alternatives under NEPA. The purpose of this notice is to inform the public of the availability of the Draft PDARP/PEIS and to seek public comments on the assessment of the Trustees' natural resources and programmatic restoration alternatives to restore these natural resources.

DATES

Comments Due Date—We will consider public comments received on or before 60 days from the public availability of the document. Additional details regarding the comment period will be available at <http://la-dwh.com> once the document is published.

Public Meetings—The Trustees will schedule a series of public meetings to facilitate public review and comment on the Draft PDARP/PEIS. Both written and verbal comments will be taken at each public meeting. The Trustees will hold an open house for each meeting followed by a formal meeting. Additional details regarding meeting information, including venues, will be published in local newspapers and will be posted on the web at <http://la-dwh.com/>. Each public meeting will include a presentation of the Draft PDARP/PEIS. The public meeting schedule has yet to be announced. Please visit <http://la-dwh.com> for further updates regarding public meetings in Louisiana.

ADDRESSES

Obtaining the Document—You will be able to download the Draft PDARP/PEIS, which is expected to be released early October 2015, at <http://la-dwh.com/>. Alternatively, you will be able to request a CD of the document (see *For Further Information Contact* section below). You will also be able to review copies of the document at the public repositories listed at <http://la-dwh.com/>.

Submission of Comments—You may submit comments on the Draft PDARP/PEIS by one of the following methods:

- a). Via the web—<http://la-dwh.com/>.
- b). For electronic submission of comments containing attachments, email jenny.kurz@la.gov.
- c). Via U.S. Mail—Louisiana Coastal Protection & Restoration Authority, ATTN: Jenny Kurz, P.O. Box 44027, Baton Rouge, LA 70804; or U.S. Fish & Wildlife Service, P.O. Box 49567, Atlanta, GA 30345. Submissions must be postmarked no later than 60 days after the release date of the Draft PDARP/PEIS.

For Further Information Contact—Jenny Kurz at jenny.kurz@la.gov.

Supplementary Information—Background

On or about April 20, 2010, the mobile offshore drilling unit *Deepwater Horizon*, which was being used to drill a well for BP Exploration and Production, Inc. (BP) in the Macondo prospect (Mississippi Canyon 252 - MC 252),

experienced a significant explosion, fire, and subsequent sinking in the Gulf of Mexico, resulting in an unprecedented volume of oil and other discharges from the rig and from the wellhead on the seabed for a period of over three months. The *Deepwater Horizon* Oil Spill is the largest oil spill in U.S. history, discharging millions of barrels of oil over a period of 87 days. In addition, well over 1 million gallons of dispersants were applied to the waters of the spill area in an attempt to disperse the spilled oil. An undetermined amount of natural gas was also released into the environment as a result of the spill. Affected resources include ecologically, recreationally, and commercially important species and their habitats in the Gulf of Mexico and along the coastal areas of Alabama, Florida, Louisiana, Mississippi, and Texas.

The State and Federal Natural Resource Trustees (Trustees) are in the final stages of conducting the natural resource damage assessment for the *Deepwater Horizon* oil spill under the Oil Pollution Act 1990 (OPA; 33 U.S.C. 2701 *et seq.*). Pursuant to OPA, Federal and State agencies and Indian Tribes may act as trustees on behalf of the public to assess natural resource injuries and losses, and to determine the actions required to compensate the public for those injuries and losses. OPA further instructs the designated trustees to develop and implement a plan for the restoration, rehabilitation, replacement, or acquisition of the equivalent of the injured natural resources under their trusteeship, including the loss of use and services from those resources from the time of injury until the time of restoration to baseline (the resource quality and conditions that would exist if the spill had not occurred) is complete.

The Trustees are:

- U.S. Department of the Interior (DOI), as represented by the National Park Service, U.S. Fish and Wildlife Service, and Bureau of Land Management;
- National Oceanic and Atmospheric Administration (NOAA), on behalf of the U.S. Department of Commerce;
- U.S. Department of Agriculture (USDA);
- U.S. Department of Defense (DOD);
- U.S. Environmental Protection Agency (USEPA);
- State of Louisiana Coastal Protection and Restoration Authority, Oil Spill Coordinator's Office, Department of Environmental Quality, Department of Wildlife and Fisheries, and Department of Natural Resources;
- State of Mississippi Department of Environmental Quality;
- State of Alabama Department of Conservation and Natural Resources and Geological Survey of Alabama;
- State of Florida Department of Environmental Protection and Fish and Wildlife Conservation Commission; and
- For the State of Texas: Texas Parks and Wildlife Department, Texas General Land Office, and Texas Commission on Environmental Quality.

INVITATION TO COMMENT

The Trustees will seek public review and comment on the assessment of the Trustees' natural resources and restoration alternatives and supporting analysis included in

the Draft PDARP/PEIS. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment, including your personal identifying information, may be made publicly available at any time.

ADMINISTRATIVE RECORD

When they are completed, the documents comprising the Administrative Record will be available electronically at the following locations:

<http://www.doi.gov/deepwaterhorizon>; or

<http://la-dwh.com/AdminRecord.aspx>.

AUTHORITY

The authority of this action is the Oil Pollution Act of 1990 (33 U.S.C. 2701 *et seq.*), the implementing Natural Resource Damage Assessment regulations found at 15 CFR 990, the Louisiana Oil Spill Prevention and Response Act [La. R.S. §§30:2451-2496 (2010)], and the implementing Natural Resource Damage Assessment Regulations found at *Louisiana Administrative Code* 43:101 *et seq.*

Kyle Graham
Executive Director

1509#057

POTPOURRI

Office of the Governor Coastal Protection and Restoration Authority

Deepwater Horizon Oil Spill: Final Phase IV Early
Restoration Plan and Environmental Assessments

ACTION:

Notice of Availability of Final Plan

SUMMARY:

In accordance with the Oil Pollution Act of 1990 (OPA), the Louisiana Oil Spill Prevention and Response Act (OSPRA), and the National Environmental Policy Act (NEPA), notice is hereby given that the Federal and State Deepwater Horizon Oil Spill natural resource trustee agencies for Louisiana, Mississippi, Alabama, Florida, and Texas (Trustees) have prepared a Final Phase IV Early Restoration Plan and Environmental Assessments (Final Phase IV ERP/EA) describing and proposing a suite of early restoration projects intended to continue the process of restoring natural resources and services injured or lost as a result of the Deepwater Horizon Oil Spill, which occurred on or about April 20, 2010, in the Gulf of Mexico. The Final Phase IV ERP/EA proposes 10 early restoration projects that are consistent with the early restoration program alternatives selected in the Final Phase III Early Restoration Plan/Programmatic Environmental Impact Statement (Phase III ERP/PEIS). The Final Phase IV ERP/EA also includes a notice of change and supporting analysis for one Phase III Early Restoration Project, "Enhancement of Franklin County Parks and Boat Ramps Eastpoint Fishing Pier Improvements". The purpose of this notice is to inform the public of the availability of the Final Phase IV ERP/EA, which occurred on September 16, 2015.

ADDRESSES:

Obtaining the Document: You may download the Final Phase IV ERP/EA at <http://losco-dwh.com/>. Alternatively, you may request a CD of the document (see For Further Information Contact section below). You may also review copies of the document at the public facilities listed at <http://losco-dwh.com/>.

FOR FURTHER INFORMATION CONTACT:

Jenny Kurz at jenny.pettiss@la.gov

SUPPLEMENTARY INFORMATION:

Introduction

On or about April 20, 2010, the mobile offshore drilling unit Deepwater Horizon, which was being used to drill a well for BP Exploration and Production, Inc. (BP) in the Macondo prospect (Mississippi Canyon 252 - MC 252), experienced a significant explosion, fire, and subsequent sinking in the Gulf of Mexico, resulting in an unprecedented volume of oil and other discharges from the rig and from the wellhead on the seabed for a period of over three months. The Deepwater Horizon Oil Spill is the largest oil spill in U.S. history, discharging millions of barrels of oil over a period of 87 days. In addition, well over 1 million gallons of dispersants were applied to the waters of the spill area in an attempt to disperse the spilled oil. An undetermined amount of natural gas was also released into the environment as a result of the spill. Affected resources include ecologically, recreationally, and commercially important species and their habitats in the Gulf of Mexico and along the coastal areas of Alabama, Florida, Louisiana, Mississippi, and Texas.

The State and Federal Natural Resource Trustees (Trustees) are conducting the natural resource damage assessment for the Deepwater Horizon oil spill under the Oil Pollution Act 1990 (OPA; 33 U.S.C. 2701 et seq.). Pursuant to OPA, Federal and State agencies and Indian Tribes may act as trustees on behalf of the public to assess natural resource injuries and losses, and to determine the actions required to compensate the public for those injuries and losses. OPA further instructs the designated trustees to develop and implement a plan for the restoration, rehabilitation, replacement, or acquisition of the equivalent of the injured natural resources under their trusteeship, including the loss of use and services from those resources from the time of injury until the time of restoration to baseline (the resource quality and conditions that would exist if the spill had not occurred) is complete. Pursuant to the process articulated in the Framework for Early Restoration Addressing Injuries Resulting from the Deepwater Horizon Oil Spill (Framework Agreement), the Trustees previously selected, and BP agreed to fund, a total of 54 early restoration projects, expected to cost a total of approximately \$700 million, through the Phase I Early Restoration Plan/Environmental Assessment (Phase I ERP/EA), Phase II Early Restoration Plan/Environmental Review (Phase II ERP/ER), and the Programmatic and Phase III Early Restoration Plan and Early Restoration Programmatic Environmental Impact Statement (Phase III ERP/PEIS). These plans are available at: <http://www.gulfspillrestoration.noaa.gov/restoration/early-restoration/>.

The Trustees are:

- U.S. Department of the Interior (DOI), as represented by the National Park Service, U.S. Fish and Wildlife Service, and Bureau of Land Management;
- National Oceanic and Atmospheric Administration (NOAA), on behalf of the U.S. Department of Commerce;
- U.S. Department of Agriculture (USDA);
- U.S. Department of Defense (DOD);
- U.S. Environmental Protection Agency (USEPA);
- State of Louisiana Coastal Protection and Restoration Authority, Oil Spill Coordinator's Office, Department of Environmental Quality, Department of Wildlife and Fisheries, and Department of Natural Resources;
- State of Mississippi Department of Environmental Quality;
- State of Alabama Department of Conservation and Natural Resources and Geological Survey of Alabama;
- State of Florida Department of Environmental Protection and Fish and Wildlife Conservation Commission; and
- For the State of Texas: Texas Parks and Wildlife Department, Texas General Land Office, and Texas Commission on Environmental Quality.

Background

On April 20, 2011, BP agreed to provide up to \$1 billion toward early restoration projects in the Gulf of Mexico to address injuries to natural resources caused by the Deepwater Horizon Oil Spill. The Framework Agreement represents a preliminary step toward the restoration of injured natural resources and is intended to expedite the start of restoration in the Gulf in advance of the completion of the injury assessment process. The Framework Agreement provides a mechanism through which the Trustees and BP can work together "to commence implementation of early restoration projects that will provide meaningful benefits to accelerate restoration in the Gulf as quickly as practicable" prior to the resolution of the Trustees' natural resource damages claim. Early restoration is not intended to and does not fully address all injuries caused by the Deepwater Horizon Oil Spill. Restoration beyond early restoration projects will be required to fully compensate the public for natural resource losses, including recreational use losses, from the Deepwater Horizon Oil Spill.

The Trustees have actively solicited public input on restoration project ideas through a variety of mechanisms, including public meetings, electronic communication, and creation of a Trustee-wide public Web site and database to share information and receive public project submissions. Their key objective in pursuing early restoration is to secure tangible recovery of natural resources and natural resource services for the public's benefit while the longer term process of fully assessing injury and damages is under way. The Trustees released, after public review of the drafts, the Phase I ERP/EA (which included eight early restoration projects) and the Phase II ERP/ER (which included an additional two projects) in April and December 2012, respectively. After public review, the Trustees released the

Phase III ERP/PEIS, which included an additional 44 early restoration projects, on June 26, 2014. Subsequently, the Trustees approved the Phase III ERP/PEIS in a Record of Decision on October 31, 2014.

On May 20, 2015, the Trustees made available to the public the Draft Phase IV Early Restoration Plan and Environmental Assessments (Draft Phase IV ERP/EA) for review and comment. The public comment period lasted from May 20 until July 6, 2015. Six public meetings were held by the Trustees to facilitate public comment on the Draft Phase IV ERP/EA. The Trustees proposed 10 additional early restoration projects in Phase IV to address injuries from the Deepwater Horizon Oil Spill. The 10 projects contained in this Final Phase IV ERP/EA are consistent with the Programmatic ERP and PEIS included in the Final Phase III ERP/PEIS previously developed by the Trustees. The Trustees proposed these projects while continuing to work with BP to develop other potential early restoration projects in accordance with the Framework Agreement.

Overview of the Final Phase IV ERP/EA

The Final Phase IV ERP/EA is being released in accordance with the Oil Pollution Act (OPA), the Natural Resource Damage Assessment (NRDA) regulations found in the Code of Federal Regulations (CFR) at 15 CFR 990, the National Environmental Policy Act (42 U.S.C. 4321 et seq.), and the Framework for Early Restoration Addressing Injuries Resulting from the Deepwater Horizon Oil Spill. The Final Draft Phase IV ERP/EA includes 10 Early Restoration projects proposed by the Trustees. The total estimated cost for proposed Phase IV projects is approximately \$134 million. The proposed projects are listed as follows:

- Texas Rookery Islands
- Restore Living Shorelines and Reefs in Mississippi Estuaries
- Bike and Pedestrian Use Enhancements at Davis Bayou, Mississippi District, Gulf Islands National Seashore
- Bon Secour National Wildlife Refuge Trail Enhancement Project, Alabama
- Osprey Restoration in Coastal Alabama
- Point aux Pins Living Shoreline
- Shell Belt and Coden Belt Roads Living Shoreline
- Seagrass Recovery Project at Gulf Islands National Seashore, Florida District
- Sea Turtle Early Restoration
- Pelagic Longline Bycatch Reduction Project

Details on the proposed projects are provided in the Final Phase IV ERP/EA. The Final Phase IV ERP/EA also includes a notice of change and supporting analysis for one Phase III Early Restoration Project, “Enhancement of Franklin County Parks and Boat Ramps—Eastpoint Fishing Pier Improvements.” The proposed restoration projects are intended to continue the process of using early restoration funding to restore natural resources, ecological services, and recreational use services injured or lost as a result of the Deepwater Horizon Oil Spill. The Trustees considered hundreds of projects leading to the identification of these 10 projects and considered both ecological and recreational use restoration projects to restore injuries caused by the Deepwater Horizon Oil Spill, addressing both the physical

and biological environment, as well as the relationship people have with the environment. The early restoration actions in the Final Phase IV ERP/EA are not intended to and do not fully address all injuries caused by the spill or provide the extent of restoration needed to make the public and the environment whole. The Trustees may propose additional early restoration projects in the future.

Administrative Record

The documents comprising the Administrative Record can be viewed electronically at the following locations:

- <http://www.doi.gov/deepwaterhorizon>; or
- <http://losco-dwh.com/AdminRecord.aspx>.

Authority

The authority of this action is the Oil Pollution Act of 1990 (33 U.S.C. 2701 et seq.), the implementing Natural Resource Damage Assessment regulations found at 15 CFR 990, the Louisiana Oil Spill Prevention and Response Act [La. R.S. §§30:2451-2496 (2010)], and the implementing Natural Resource Damage Assessment Regulations found at La. Admin. Code 43:101 et seq.

Kyle Graham
Executive Director

1509#001

POTPOURRI

**Department of Natural Resources
Office of Conservation**

Orphaned Oilfield Sites

Office of Conservation records indicate that the Oilfield Sites listed in the table below have met the requirements as set forth by Section 91 of Act 404, R.S. 30:80 et seq., and as such are being declared Orphaned Oilfield Sites.

Operator	Field	District	Well Name	Well Number	Serial Number
Cliffs Drilling Company	Washington	L	Thistlethwaite	001	150433 (30)
Emerson Oil Corp	Port Barre	L	Sibille	005	21176
C. A. Hillburn	Caddo Pine Island	S	Forrester Downer	001	25251
United Southern Resources Inc.	Monroe	M	Strother	003	179683
United Southern Resources Inc.	Monroe	M	M J & G Savage	001	181303
United Southern Resources Inc.	Monroe	M	M J & G Savage	002	181304
United Southern Resources Inc.	Monroe	M	Strother 85-A	001	201207

Operator	Field	District	Well Name	Well Number	Serial Number
United Southern Resources Inc.	Monroe	M	J D Vestal 85-A	001	201208
United Southern Resources Inc.	Monroe	M	Strother 85-A	002	201214
United Southern Resources Inc.	Monroe	M	J D Vestal 85-A	002	201249
United Southern Resources Inc.	Monroe	M	J D Vestal 85-A	003	201250
United Southern Resources Inc.	Monroe	M	C L Golden	001	201697
United Southern Resources Inc.	Monroe	M	M & BK Watson	001	201698
United Southern Resources Inc.	Monroe	M	M & BK Watson 86B	002	205098

Operator	Field	District	Well Name	Well Number	Serial Number
United Southern Resources Inc.	Monroe	M	Blanche Cummings et al	003	206033
United Southern Resources Inc.	Monroe	M	Jack Dean	001	206034
United Southern Resources Inc.	Monroe	M	Blanche Cummings et al	002	206570
United Southern Resources Inc.	Monroe	M	Jack Dean	002	208555
United Southern Resources Inc.	Monroe	M	Jack Dean	003	208556
United Southern Resources Inc.	Monroe	M	M & BK Watson	003	211059

James H. Welsh
Commissioner

1509#036

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