**RULE**

**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 has amended LAC 48:I.Chapter 125 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2116. This 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 I. General Administration**
**Subpart 5. Health Planning**

**Chapter 125. Facility Need Review**

**Subchapter A. General Provisions**

**§12501. Definitions**

A. …

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*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".

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*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.

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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 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:

Kathy H. Kliebert

Secretary

**RULE**

**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 has amended 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 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 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.

Kathy H. Kliebert

Secretary

**RULE**

**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 has amended LAC 48:I.Chapter 50 and adopted Chapter 51 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2120.2. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, 49:950 et seq.

**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**

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*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.

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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:

Kathy H. Kliebert

Secretary

**RULE**

**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 have amended 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 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 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 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.

Kathy H. Kliebert

Secretary

**RULE**

**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 has amended 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 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 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.

Kathy H. Kliebert

Secretary

**RULE**

**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 has amended LAC 48:I.Chapter 78 as authorized by R.S 36:254 and R.S. 40:2198.11-13. This 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 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. 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;

l. 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:

Kathy H. Kliebert

Secretary

**RULE**

**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 has repealed the September 20, 1975 Rule governing physician visits, and has adopted 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 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 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:

Kathy H. Kliebert

Secretary

**RULE**

**Department 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 has amended 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 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 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.

Kathy H. Kliebert

Secretary