Subchapter E. Reserved

Subchapter F. Vendor Payments

§10147. General Provisions

A. Residents Receiving Care Under Title XIX (Medicaid) Only

1. The BHSF Medicaid Program shall determine the resident's applicable income (liability when computing facility vendor payments. Vendor payments are subject to the following conditions.

a. Vendor payments shall begin with the first day the resident is determined categorically and medically eligible or the date of admission, if later.

b. Vendor payments shall be made as determined by the facility per diem rate less the resident's per diem applicable income for the number of eligible days.

c. If a resident transfers from one facility to another, the vendor payments to each facility is the facility's per diem rate for the number of days in the facility, less the resident's per diem applicable income for the total number of days in each facility.

2. Retroactive Payment. When individuals enter a facility before their Medicaid eligibility has been established, payment for facility services is made retroactive to the first date of eligibility after admission.

3. Resident Personal Care Income. The facility shall not require that any part of a resident's personal care income be paid as a part of the facility's fee. Personal care income is an amount set aside from a resident's available income to be used for personal needs. The amount is determined by the Department of Health and Hospitals.

a. The facility shall not permit tips for services rendered by facility employees.

B. Residents Receiving Care Under Title XVIII (Medicare). Resident income shall not be considered in determining vendor payments for a period of up to 100 days provided he/she remains eligible for Title XVIII-A (Medicare). This also includes the period for which coinsurance is being paid by the Medicaid Program.

C. Timely Filing For Reimbursements. Vendor payments cannot be made when more than 12 months have elapsed between the month of initial service and submittal of a claim for these services. Payment of claims more than 12 months old require the approval of the Bureau of Health Services Financing Program Operations Section.

D. Temporary Absence of the Resident; No Evacuation. Payment procedures for periods of temporary absnce are subject to the following conditions.

1. The facility keeps a bed available for the resident's return and provides notification in accordance with the Bed Reservation Policy requirements in the chapter entitled *Transfer and Discharge Procedures.*

2. The absence is for one of the following reasons:

a. hospitalization for an acute condition including psychiatric stays, which does not exceed 5 days per hospitalization;

b. home leave.

NOTE: Payment cannot be mad for hospital leave days while a resident is receiving swing bed SNF services.

3. When the hospital has determined that discharge is appropriate for a resident who had been admitted to the hospital from a nursing facility, the nursing facility shall readmit this resident on the date the physician writes the discharge regardless of the hour of the day or the day of the week. This includes holidays and weeks.

4. Payment will not be made to the nursing facility for hospital leave days beyond the date of the physician's date of discharge from the hospital.

5. Home leave (leave of absence), is defined as a visit with relatives or friends which does not exceed 9 days per calendar year. Institutionalization is not broken if the absence does not exceed 14 days and if the facility has not discharged the resident.

NOTE: Elopements (unauthorized absences under the plan of care) count against allowable home leave days.

6. The period of absence shall be determined by counting the first day of absence as the day the resident leaves the facility.

7. Only a period of 24 continuous hours or mroe shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or home visit is broken only if the resident returns to the facility for 24 hours or longer.

8. Upon admission, a resident must remain in the facility at least 24 hours in order for the facility to submit a payment claim for a day of service or reserve a bed.

EXAMPLE: A resident admitted to a nursing facility in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for facility services.

9. If a resident transfers from one facility to another, the unused home leave days for that calendar year also transfer. No additional leave days are allocated.

10. The facility shall promptly notify the Parish/Regional BHSF Office of absences beyond the applicable, 14, 5, or 4 day limitations.

E. Temporary Absence Due To Evacuation. When local conditions require evacuation of residents in nursing facilities, the following payment procedures apply.

1. When the resident is evacuated for less than twenty four (24) hours, the monthly vendor payment to the facility is not interrupted.

2. When the staff is sent with the resident(s) to the evacuation site, the monthly vendor payment to the facility is not interrupted.

3. When the resident is evacuated to family or friend's home, at the facility's request, the facility shall not submit a claim for a day of service or leave day, and patient liability shall not be collected.

4. When the resident goes home at the family's request or on their own initiative, a leave day shall be charged.

5. When the resident is admitted to the hospital for the purpose of evacuation of the nursing facility, Medicaid payment shall not be made for the hospital charges.

F. Resident Deposits. A facility shall neither require nor accept an advance deposit from a resident whose Medicaid eligibility has been established.

EXCEPTION: A facility may require an advance deposit for the current month only on the part of the total payment which is the resident's liability.

1. If advance deposits or payments are required from residents or residents legal representative or sponsor upon admission when Medicaid eligibility has not been established, then such a deposit shall be refunded or credited to the person upon receipt of vendor payment.

2. Credit on the facility's books in lieu of a refund to the resident or resident's legal representative or sponsor is acceptable within the following limitations:

a. Such credit shall not exceed an amount equal to the resident's liability for 60 days following the date the resident was determined eligible for Medicaid.

b. Any deposit exceeding such an amount shall be refunded within five working days to the resident or resident's legal representative or sponsor.

G. Refunds to Bureau of Health Services Financing Medicaid Program

1. A Non-Participating Facility. Vendor payments made for the services performed while a facility is in a non-participating status shall be refunded to the Department of Health and Hospitals, Office of Management and Finance.

The refund shall be made payable to the Bureau of Health Services Financing Medicaid Program.

2. A Participating Facility. A currently participating Medicaid facility shall correct billing or payment errors by the use of appropriate Adjustment/Void or Resident Liability (PLI) adjustment form.

H. Refunds to Residents. Advance payments for a resident's liability (applicable income) shall be refunded promptly if he/she leaves the facility before the end of the month. The facility shall adhere to the following procedures for the refunds.

1. The proportionate amount for the remaining days of the month shall be refunded to the resident or the resident's legal representative or sponsor no later than the end of the month following discharge. If the resident has not yet been certified, then the procedures spelled out in Refunds to Residents, paragraph one, shall apply.

2. No penalty shall be charged to the resident or resident's legal representative or sponsor even if the circumstances surrounding the discharge occurred as follows:

a. without prior notice;

b. within the initial month; and

c. within some other "minimum stay" period established by the facility.

3. Proof of refund of the unused portion of the applicable income shall be furnished to the BHSF Medicaid Program upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§20021. Leave of Absence Days
[Formerly LAC 50:VII.1321]

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days for nursing facilities with occupancy rates equal to or greater than 90 percent shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

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 35:1899 (September 2009), amended LR 41:133 (January 2015).