RULE

Department of Health
Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Major Medical Centers
(LAC 50:V.2715)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.2715 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. This Rule is hereby adopted on the day of promulgation.

TITLE 50

PUBLIC HEALTH–MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 3. Disproportionate Share Hospital Payments

Chapter 27. Qualifying Hospitals

§2715. Major Medical Centers Located in Central and Northern Areas of the State

A. Effective for dates of service on or after June 30, 2016, hospitals qualifying for payments as major medical centers located in the central and northern areas of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative regions 6, 7, or 8;

2. have at least 200 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1 – 18, for the state fiscal year ending June 30, 2015. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;

3. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and

4. such qualifying hospital (or its affiliate) does have a memorandum of understanding executed on or after June 30, 2016 with Louisiana State University, School of Medicine, the purpose of which is to maintain and improve access to quality care for Medicaid patients in connection with the expansion of Medicaid in the state through the promotion, expansion, and support of graduate medical education and training.

B. Payment Methodology. Effective for dates of service on or after June 30, 2016, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. Additional payments shall only be made after finalization of the Centers for Medicare and Medicaid Services' (CMS) mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on these reported audit results. If the hospitals' aggregate amount of

underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid hospitals shall be paid on a pro rata basis calculated using each hospital's amount underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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, Bureau of Health Services Financing, LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Facility Need Review
Behavioral Health Services Providers
(LAC 48:I.Chapter 125)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 125 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. This Rule is hereby adopted on the day of promulgation.

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. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

***

Behavioral Health Services (BHS)-mental health services, substance abuse/addiction treatment services, or combination of such services, for adults, adolescents and children.

Behavioral Health Services Provider–a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services or, presents itself to the public as a provider of behavioral health services.

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 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 41:2636 (December 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§12503. General Information

A. - B. ...

C. The department will also conduct an FNR for the following provider types to determine if there is a need to license additional units, providers or facilities:

1. - 3. ...

4. hospice providers or inpatient hospice facilities;

5. pediatric day health care facilities; and

6. behavioral health services (BHS) providers that provide psychosocial rehabilitation (PSR) and/or community psychiatric support and treatment (CPST) services.

D. - F.4. ...

G. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers, ICFs/DD, ADHC providers, hospice providers, BHS providers, and pediatric day health care centers that meet one of the following conditions:

1. ...

2. existing licensed ICFs-DD that are converting to the Residential Options Waiver;

3. – 5.c. ...

d. became licensed as a PDHC by the department no later than December 31, 2014;

6. behavioral health services providers that are licensed to provide PSR and/or CPST, or that have submitted a completed application for licensure as a BHS provider that includes PSR and/or CPST, prior to promulgation of this Rule; and

7. behavioral health services (BHS) providers that fall within the provisions of Act 33 of the 2017 Regular Session

of the Louisiana Legislature, commonly referred to as accredited mental health rehabilitation providers, that submit a completed BHS provider licensing application by December 1, 2017 and become licensed by April 1, 2018.

H. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 38:1961 (August 2012), LR 41:136 (January 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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

§12524. Behavioral Health Services Providers

A. Except as noted in Paragraph B below, no behavioral health services (BHS) providers or applicants seeking to provide psychosocial rehabilitation (PSR) and/or community psychiatric support and treatment (CPST) services shall be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR

Program has granted an approval for the issuance of a BHS provider license for such services. Once the FNR Program approval is granted, a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

B. BHS providers who fall within the provisions of Act 33 of the 2017 Regular Session of the Louisiana Legislature, commonly referred to as accredited mental health rehabilitation providers, are required to submit a BHS provider licensing application by December 1, 2017 and become licensed by April 1, 2018.

1. Beginning December 2, 2017, such an "Act 33" BHS provider that failed to submit its completed licensing application by December 1, 2017, shall be subject to FNR and shall not be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR Program has granted an approval for the issuance of a BHS provider license for such services. Once the FNR Program approval is granted, such a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

2. Beginning April 2, 2018, such an "Act 33" BHS provider that submitted its completed licensing application by December 1, 2017, but failed to become licensed by April 1, 2018, shall be subject to FNR and shall not be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR Program has granted an approval for the issuance of a BHS

provider license for such services. Once the FNR Program approval is granted, such a BHS provider is eligible to apply for a BHS provider license to provide PSR and/or CPST services.

C. The service area for proposed or existing BHS providers shall be the parish in which the provider is licensed and parishes directly adjacent to said parish.

D. Determination of Need/Approval

1. The department shall review the FNR application to determine if there is a need for an additional BHS provider to provide PSR and/or CPST services in the service area.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access behavioral health PSR and/or CPST services if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other BHS providers providing PSR and/or CPST services in the same geographic location and service area servicing the same population;

b. the number of members that the BHS provider is able to provide PSR and/or CPST services to; and

c. allegations involving issues of access to behavioral health PSR and/or CPST services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access behavioral health PSR and/or CPST services if the provider is not granted approval to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

E. Applications for approvals of BHS providers of PSR and/or CPST services submitted under these provisions are bound to the description in the application with regard to the type of services proposed, as well as to the site and location as defined in the application. FNR approval of such providers shall expire if these aspects of the application are altered or changed.

F. Facility need review approvals for behavioral health PSR and/or CPST applicants are non-transferrable and are limited to the location and the name on the original licensee.

1. A BHS provider of PSR and/or CPST services undergoing a change of location in the same licensed region shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A BHS provider undergoing a change of location outside of the licensed region shall submit a new completed FNR application and required fee and undergo the FNR approval process.

2. A BHS provider of PSR and/or CPST services undergoing a change of ownership shall submit a new completed application and required fee to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which shall show the seller's or transferor's intent to relinquish the FNR approval.

3. Facility need review approval of a licensed BHS provider of PSR and/or CPST services shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

4. Facility need review approved BHS providers of PSR and/or CPST shall become licensed no later than one year from the date of the FNR approval. Failure to meet any of the time frames in this section shall result in an automatic expiration of the FNR approval of the BHS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Laboratory and Radiology Services
Termination of Coverage for Proton Beam Radiation Therapy
(LAC 50:XIX.4334)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIX.4334 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIX. Other Healthcare Services
Subpart 3. Laboratory and Radiology Services

Chapter 43. Billing and Reimbursement

Subchapter B. Reimbursement

§4334. Radiology Services

A. – K.3. ...

L. Effective for dates of service on or after February 20, 2018, or upon promulgation of this Rule, the Medicaid Program terminates coverage and reimbursement for proton beam radiation therapy (PBRT) for recipients 21 years of age and older.

1. For recipients under the age of 21, coverage and reimbursement shall be provided when PBRT services are deemed medically necessary.

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 30:1026 (May 2004), amended LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013), LR 41:540 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Rebekah E Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Independent Review Process for Provider Claims
(LAC 50:I.3111)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:I.3111 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3111. Independent Review Process for Provider Claims

A. Right of Providers to Independent Review

1. Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for adverse determinations related to claims filed on or after January 1, 2018, a healthcare provider shall have a right to an independent review of the adverse action of the managed care organization (MCO).

2. For purposes of these provisions, adverse determinations shall refer to claims submitted by healthcare

providers for payment for services rendered to Medicaid enrollees and denied by a MCO, in whole or in part, or a claim that results in recoupment of a payment from the healthcare provider.

B. Request for Reconsideration

1. A provider shall submit a written request for reconsideration to the MCO. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the MCO, within 180 days from one of the following dates:

a. the date on which the MCO transmits remittance advice or other notice electronically;

b. 60 days from the date the claim was submitted to the MCO if the provider receives no notice from an MCO, either partially or totally, denying the claim; or

c. the date on which the MCO recoups monies remitted for a previous claim payment.

2. The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §3111.B.1, within 5 calendar days after receipt of the request, and render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

C. Independent Review Requirements

1. If the MCO upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60 days from the date the provider receives the MCO's notice of the decision of the reconsideration request, or if the MCO does not respond to the reconsideration request within the time frames allowed, the last date of the time period allowed for the MCO to respond.

2. The provider shall include a copy of the written request for reconsideration with the request for an independent review. The address to be used by the provider for submission of the request shall be P.O. Box 91283, Bin 32, Baton Rouge, LA 70821-9283.

3. If the MCO reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the MCO's decision.

4. Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same MCO when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on a medical issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 90 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. The independent reviewer may request in writing an extension of time from the department to resolve the dispute. If an extension of time is granted by the department, the independent reviewer shall provide notice of the extension to the provider and the MCO.

8. If the independent reviewer renders a decision requiring a MCO to pay any claims or portion of the claims, within 20 calendar days, the MCO shall send the provider payment in full along with 12 percent interest calculated back to the date the claim was originally denied or recouped.

9. Within 60 calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent

reviewer's decision to recover any funds awarded by the independent reviewer to the other party.

D. Independent Review Costs

1. The fee for conducting an independent review shall be paid to the independent reviewer by the MCO within 30 calendar days of receipt of a bill for services. A provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse a MCO for the fee associated with conducting an independent review when the decision of the MCO is upheld. If the provider fails to submit payment for the independent review within 10 days from the date of the decision, the MCO may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the MCO fails to pay the bill for the independent reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the MCO.

E. Independent Reviewer Selection Panel

1. The independent reviewer selection panel shall select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation to be paid to each reviewer, not to exceed $2,000 per review.

2. The panel shall consist of the secretary or his/her duly designated representative, two provider representatives and two MCO representatives.

3. Each MCO shall utilize only independent reviewers who are selected in accordance with Act 349 of the 2017 Regular Session of the Louisiana Legislature, and shall comply with the provisions of this Section in the resolution of disputed adverse determinations.

F. Penalties

1. An MCO in violation of any provision governing the independent review process herein may be subject to a penalty of up to $25,000 per violation.

2. An MCO may be subject to an additional penalty of up to $25,000 if subject to more than 100 independent reviews annually and the percentage of adverse determinations overturned in favor of the provider as a result of an independent review is greater than 25 percent.

G. Independent Review Applicability

1. Independent review shall not apply to any adverse determination:

a. associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date;

b. associated with an adverse determination involved in litigation or arbitration;

c. not associated with a Medicaid enrollee.

2. Independent review does not otherwise prohibit or limit any alternative legal or contractual remedy available to a provider to contest the partial or total denial of a claim for payment for healthcare services. Any contractual provision executed between a provider and a MCO which seeks to limit or otherwise impede the appeal process as set forth in this Section shall be null, void, and deemed to be contrary to the public policy of this state.

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, Bureau of Health Services Financing, LR 44:

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.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Member Grievances and Appeals
(LAC 50:I.Chapter 37)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.Chapter 37 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3703. Definitions

Action—Repealed.

1. – 5. Repealed.

Adverse Benefit Determination—any of the following:

1. the denial or limited authorization of a requested service, including determinations based on the type or

level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2. the reduction, suspension, or termination of a previously authorized service;

3. the denial, in whole or in part, of payment for a service;

4. the failure to provide services in a timely manner, as defined by the State;

5. the failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

6. the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductible, coinsurance, and other member financial liabilities.

Appeal—a request for review of an adverse benefit determination as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to:

1. ...

2. aspects of interpersonal relationships, such as rudeness of a provider or employee;

3. failure to respect the member's rights regardless of whether remedial action is requested; or

4. the member's rights to dispute an extension of time proposed by the MCO to make an authorization decision.

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 37:1589 (June 2011), amended LR 41:939 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3705. General Provisions

A. The MCO must have a system in place for members that includes a grievance process, an appeal process, and access to the state fair hearing process once the MCO's appeal process has been exhausted.

B. Filing Requirements

1. Authority to File. A member, or a representative of his/her choice, including a provider acting on behalf of the member and with the member's written consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative, with the member's written consent, may request a state fair hearing.

a. ...

2. Filing Timeframes. The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 60 calendar days from the date on the MCO's notice of adverse benefit determination.

3. Filing Procedures

a. ...

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file an appeal either orally or in writing. Oral appeals must be followed by a signed, written appeal unless the member requested an expedited appeal.

C. – C.1.b. ...

D. Grievance and Appeal Records

1. The MCO must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the 10-year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular 10-year period, whichever is later.

E. All state fair hearing requests shall be sent directly to the state designated entity.

1. – 1.f. Repealed.

F. The MCO will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the MCO member.

G. The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

H. Information to Providers and Subcontractors. The MCO must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

I. Recordkeeping and Reporting Requirements. Reports of grievances and resolutions shall be submitted to the department as specified in the contract. The MCO shall not modify the grievance system without the prior written approval of the department.

J. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:939 (May 2015), LR 41:2368 (November

2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3707. Handling of Member Grievances and Appeals

A. In handling grievances and appeals, the MCO must meet the following requirements:

1.- 2. ...

3. ensure that the individuals who make decisions on grievances and appeals are individuals who:

a. were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; and

b. if deciding on any of the following issues, are individuals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:

A.3.b.i. – B. ...

1. The process for appeals must:

a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution;

b. ...

c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO during the appeals process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and

1.d. – 3. ...

4. Failure to Make a Timely Decision

a. ...

b. If a determination is not made by the contractual time frames, the member’s request will be deemed to have been exhausted and the member may initiate a state fair hearing.

5. ...

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 37:1590 (June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3709. Notice of Adverse Benefit Determination

A. ...

B. Content of Notice. The notice must explain the following:

1. the adverse benefit determination the MCO or its subcontractor has taken or intends to take;

2. the reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination;

3. ...

4. the member's right to request a state fair hearing after the MCO's one-level appeal process has been exhausted;

B.5. – D.3. ...

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a denial and is thus an adverse action on the date that the timeframes expire.

1. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization

decision and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

2. The MCO may extend the 72-hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension, or if the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

F. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

F.1. - G. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1591 (June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3711. Resolution and Notification

A. The MCO must resolve each grievance and appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section. The MCO must provide written notice to all members who filed a

grievance whether the grievance was filed with the MCO or the department.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 30 days, or the timeframe established by the department, not to exceed 90 days, from the day the MCO receives the grievance.

B.2. – D. ...

E. Format of Notice

1. The MCO shall follow the method specified by the department to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of the resolution.

3. For notice of an expedited resolution, the MCO must provide written notice of the resolution and also make reasonable efforts to provide oral notice.

F. – F.2.c. ...

G. Requirements for State Fair Hearings

1. ...

2. If the member has exhausted the MCO's one-level appeal procedures, the member may initiate a state fair hearing within 120 days from the date of the MCO's notice of appeal resolution.

3. ...

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 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3713. Expedited Resolution of Appeals

A. ...

B. If the MCO denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution; and

2. make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with the decision.

C. – E.2. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:

§3715. Continuation of Services during the Pending MCO Appeal or State Fair Hearing

[Formerly LAC 50:I.3711]

A. *Timely Filing*-filing on or before the later of the following:

1. within 10 calendar days of the MCO's mailing of the notice of adverse benefit determination; or

2. the intended effective date of the MCO's proposed adverse benefit determination.

B. Continuation of Benefits. The MCO must continue the member's benefits if the:

1. – 4. ...

5. member timely files for continuation of benefits.

C. ...

1. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal or request for state fair hearing;

b. 10 calendar days pass after the MCO mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached; or

c. a state fair hearing entity issues a hearing decision adverse to the member.

d. Repealed.

D. ...

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 37:1591 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:

§3717. Effectuation of Reversed Appeal Resolutions

[Formerly LAC 50:I.3713]

A. ...

1. If the MCO or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the decision.

B. – C. ...

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 37:1592 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Psychiatric Residential Treatment Facilities
Licensing Standards
(LAC 48:I.Chapter 90)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 90 as authorized by R.S. 36:254 and R.S. 40:2009. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 48

PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 3. Licensing

Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

Subchapter A. General Provisions

§9001. Purpose

A. The purpose of this Chapter 90 is to provide for the development, establishment and enforcement of statewide standards for the care of residents who are under 21 years of age in psychiatric residential treatment facilities (PRTFs) participating in the Medicaid Program, to ensure maintenance of these standards, and to regulate conditions in these facilities

through a program of licensure which shall promote the health, safety and welfare of residents of PRTFs participating in the Medicaid Program.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 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 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9003. Definitions

A. The following defines selected terminology used in connection with this Chapter 90.

***

Cessation of Business-provider is non-operational and/or has stopped offering or providing services to the community.

***

Department (LDH)—the *Louisiana* Department of Health.

***

Documentation—written evidence or proof, including signatures of appropriate staff and date, shall be maintained on site and available for review.

DSS—Repealed.

***

HSS—the Department of Health, Health Standards Section.

***

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

***

Mental Health Specialist (MHS)—a person who delivers direct care services under the direct supervision of a LMHP or

MHP and who meets one of the following criteria, as documented by the provider:

a. has completed at least two years of education from an accredited college or university; or

b. has a high school diploma or equivalent and has completed two years of documented experience providing direct care services in a mental health, physical health, social services, educational or correctional setting.

c. - d. Repealed.

***

Non-Operational-the HCBS provider location is not open for business operation on designated days and hours as stated on the licensing application and business location signage.

***

OBH—the Department of Health, Office of Behavioral Health.

OCS—Repealed.

OPH—the Department of Health, Office of Public Health.

***

OYD—Repealed.

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), LR 39:2510 (September 2013), LR 42:277 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter B. Licensing

§9007. General Provisions

A. - G. ...

H. Plan Review. Construction documents (plans and specifications) are required to be submitted and approved by both the OSFM and the Department of Health as part of the licensing procedure and prior to obtaining a license.

1. - 1.a. ...

i. One set of the final construction documents shall be submitted to the OSFM for approval. The Fire Marshal’s approval letter and final inspection shall be sent to the LDH.

ii. One set of the final construction documents shall be submitted to the OSFM for the LDH plan review along with the appropriate review fee and a “plan review application form” for approval.

b. - c.i. ...

ii. the latest LSUCCC adopted edition of the *International Building Code*; and

iii. the current licensing standards for psychiatric residential treatment facilities.

iv. Repealed.

d. Construction Document Preparation. Construction documents submitted to LDH shall be prepared only by a Louisiana licensed architect or licensed engineer as governed by the licensing laws of the state for the type of work to be performed. These documents shall be of an architectural or engineering nature and thoroughly illustrate the project that is accurately drawn, dimensioned, and contain noted plans, details, schedules and specifications. At a minimum the following shall be submitted:

i. - vi. ...

2. Waivers. The secretary of LDH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of, or otherwise required under, the provisions of the state sanitary code. The facility shall submit a waiver request in writing to HSS. The facility shall demonstrate how patient safety and quality of care offered is not compromised by the waiver, and must demonstrate the undue hardship imposed on the facility if the waiver is not granted. The facility shall demonstrate their ability to completely

fulfill all other requirements of service. The department will make a written determination of the requests.

a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:372 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9009. Initial Licensing Application Process

A. ...

B. Licensed DCFS child residential facilities that are converting to PRTFs shall comply with all of the initial licensure requirements, except plan review, and may be eligible for the exception to the bedroom space requirement of this Chapter.

C. An applicant shall submit a completed initial licensing application packet to the department, which shall include:

1. ...

2. a copy of the approval letters of the architectural and LDH licensing facility plans for the PRTF from the OSFM, and any other office/entity designated by the

department to review and approve the facility's architectural plans, if the facility shall go through plan review;

3. - 9. ...

D. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a PRTF shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

E. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant shall notify the department that the PRTF is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a PRTF shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the PRTF will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:373 (February 2012), amended LR 39:2510 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9011. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. - 2.a. ...

b. The facility shall submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

2.c. - 4.c.ii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:373

(February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9013. Deemed Status

A. A licensed PRTF may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site licensing survey provided that:

1. ...

2. all services provided under the PRTF license shall be accredited; and

A.3. - D. ...

1. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:374 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9017. Changes in Licensee Information or Personnel

A. ...

B. Any change regarding the PRTF's name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the change. Any change regarding the PRTF name or "doing business as" name requires a change to the facility

license and the required fee for the issuance of an amended license.

C. - D.3. ...

E. Any request for a duplicate license shall be accompanied by the required fee.

F. ...

1. Written notice of intent to relocate shall be submitted to HSS when the plan review request is submitted to the department for approval.

2. Relocation of the facility's physical address results in a new anniversary date and the full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9019. Cessation of Business

A. Except as provided in §9089 of these licensing regulations, a license shall be immediately null and void if a PRTF becomes non-operational.

B. - D. ...

E. Prior to the effective date of the closure or cessation of business, the PRTF shall:

1. - 1.b. ...

c. the parent(s) or legal guardian or legal representative of each resident; and

2. provide for an orderly discharge and transition of all of the residents in the facility.

F. In addition to the advance notice of voluntary closure, the PRTF shall submit a written plan for the disposition of residents' medical records for approval by the department. The plan shall include the following:

1. ...

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's residents' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the resident or authorized representative, upon presentation of proper authorization(s); and

F.3.b. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9021. Renewal of License

A. To renew a license, a PRTF shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

A.1. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:376 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9025. Notice and Appeal of License Denial, License Revocation, and Denial of License Renewal

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The PRTF has a right to an informal reconsideration of the license denial, license revocation, or denial of license

renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The PRTF shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. - 7. ...

C. The PRTF has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The PRTF shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or denial of license renewal.

a. The facility may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt

of the notice of the license denial, license revocation, or denial of license renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the facility shall be allowed to continue to operate and provide services until such time as the DAL issues a final administrative decision.

a. ...

4. Correction of a violation or a deficiency which is the basis for the license denial or revocation shall not be a basis for the administrative appeal.

D. ...

E. If a timely administrative appeal has been filed by the facility on a license denial, denial of license renewal, or license revocation, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. If the final DAL decision is to reverse the license denial, the denial of license renewal, or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing fees or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to affirm the denial of license renewal or the license revocation, the facility shall discharge any and all residents receiving services according to the provisions of this Chapter. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where the residents' records will be stored.

F. - G.2. ...

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five calendar days of receipt of the notice of the results of the follow-up survey from the department.

4. The provider shall 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 Division of Administrative Law, or its successor.

H. - I.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:377 (February 2012), amended LR 42:278 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9027. Complaint Surveys

A. - E. ...

F. LDH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any provider staff, resident, or participant, as necessary or required to conduct the survey.

G. A PRTF which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department’s Health Standards Section. The department shall receive the written

request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation that resulted from his/her complaint. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department shall receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. - J. ...

1. - 2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:378 (February 2012), amended LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9029. Statement of Deficiencies

A. - C.3. ...

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, license revocations, and denial of license

renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:379 (February 2012), amended LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter C. Organization and Administration

§9033. Governing Body [Formerly §9029]

A. The PRTF shall have either an effective governing body or individual(s) legally responsible for the conduct of the PRTF operations. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

B. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:59 (January 2004), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:380 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9035. Administrative Policies and Records

[Formerly §9031]

A. Every PRTF shall have policies that are clearly written and current. All policies shall be available for review by all staff and LDH personnel. All policies shall be available for review upon request by a resident or a resident's parent or legal guardian.

B. ...

C. The PRTF shall have policies governing:

1. - 6. ...

7. mandatory reporting of abuse or neglect;

8. - 11. ...

12. the photographing and audio or audio-visual recording of residents and clarification of the agency's prohibited use of social media to ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media;

13. all hazards risk assessment and emergency/disaster procedures, including the provision that when the PRTF has an interruption in services or a change in the

licensed location due to an emergency situation, the PRTF shall notify the HSS no later than the next stated business day;

C.14. - D.1.i. ...

2. Notification of Facility Policy Regarding the Use of Restraint and Seclusion. At admission, the facility shall:

a. ...

b. communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility shall provide interpreters or translators;

c. obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff shall file this acknowledgment in the resident's record; and

d. ...

i. The facility’s policy shall provide contact information, including the phone number and mailing address, for the appropriate state protection and advocacy organization.

E. - E.1.e. ...

2. The facility policy shall prohibit:

a. shaking, striking, spanking or any cruel treatment;

b. - k. ...

3. The PRTF shall satisfy all of the requirements contained in federal and state laws and regulations regarding the use of restraint or seclusion, including application of time out.

F. Resident Abuse or Neglect

1. The provider shall have comprehensive written procedures concerning resident abuse or neglect including:

1.a. - 2. ...

3. Staff shall report any case of suspected resident abuse or neglect to both HSS and the DCFS, Child Welfare Division by no later than close of business the next business day after a case of suspected resident abuse or neglect. The report shall include:

a. - e. ...

4. In the case of a minor, the facility shall notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the suspected resident abuse or neglect.

5. Staff shall document in the resident's record that the suspected resident abuse or neglect was reported to both HSS and the DCFS, Child Welfare Division, including the

name of the person to whom the incident was reported. A copy of the report shall be maintained in the resident's record.

G. The facility shall report each serious occurrence to both HSS and, unless prohibited by state law, the DCFS, Child Welfare Division. Serious occurrences that shall be reported include a resident's death, or a serious injury to a resident or a suicide attempt by a resident.

1. Staff shall report any serious occurrence involving a resident to both HSS and the DCFS, Child Welfare Division by no later than close of business the next business day after a serious occurrence. The report shall include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility. The facility shall conduct an investigation of the serious occurrence to include interviews of all staff involved, findings of the investigation, and actions taken as a result of the investigation.

2. In the case of a minor, the facility shall notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

3. Staff shall document in the resident's record that the serious occurrence was reported to both HSS and the DCFS, Child Welfare Division, including the name of the person

to whom the incident was reported. A copy of the report shall be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

H. - L. ...

1. The PRTF shall ensure the confidentiality and security of resident records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations and any Louisiana state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA Privacy Regulations. Information from, or copies of records may be released only to authorized individuals, and the PRTF shall ensure that unauthorized individuals cannot gain access to or alter resident records. Original medical records shall not be released outside the PRTF unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster.

L.1.a. - M.3.d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:60 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing, LR 38:380 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter D. Human Resources

§9041. Personnel [Formerly §9043]

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

B. There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to residents, and for the ethical conduct and professional practices of its members, as well as for accounting to the governing body. The manner in which the professional staff is organized shall be consistent with the facility's documented staff organization and policies and shall pertain to the setting where the facility is located. The organization of the professional staff and its policies shall be approved by the facility's governing body.

C. The staff of a PRTF shall have the appropriate qualifications to provide the services required by its residents' comprehensive plans of care. Each member of the direct care staff may not practice beyond the scope of his/her license, certification or training.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 30:63 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:383 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9043. Personnel Qualifications and Responsibilities

A. Staffing Definitions. All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person shall be able to verify the amount of time worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:384 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9045. Personnel Orientation and Training

A. - A.1. ...

2. Orientation includes, but is not limited to:

a. - b. ...

c. fire and disaster plans including evacuations;

d. - f. ...

g. personnel policy and procedure, including the prohibited use of social media. Such training shall, at a minimum, include confidentiality of resident information, preservation of resident dignity and respect, protection of resident privacy and personal and property rights;

h. detecting and mandatory reporting of resident abuse, neglect or misappropriation of resident's funds;

A.2.i. - B.3. ...

4. Staff training shall include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

5. Staff shall be trained and demonstrate competency before participating in an emergency safety intervention.

6. All training programs and materials used by the facility shall be available for review by HSS.

B.7. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:384

(February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9047. Personnel Requirements

A. - C. ...

D. Staffing ratios listed above are a minimum standard. The PRTF shall have written policies and procedures that:

1. - 3.a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:329 (February 2017), LR 44:

Subchapter E. Facility Operations

§9063. Admission, Transfer and Discharge Requirements

A. The written description of admissions policies and criteria shall be provided to the department upon request, and made available to the resident and his/her legal representative.

B. - D. ...

E. To be admitted into a PRTF, the individual shall have received certification of need from the department or the department's designee that recommends admission into the PRTF. The PRTF shall ensure that requirements for certification are

met prior to treatment commencing. The certification shall specify that:

E.1. - G. ...

H. Voluntary Transfer or Discharge. Upon notice by the resident or authorized representative that the resident has selected another provider or has decided to discontinue services, the PRTF shall have the responsibility of planning for the resident's voluntary transfer or discharge. The transfer or discharge responsibilities of the PRTF shall include:

1. holding a transfer or discharge planning conference with the resident, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge, unless the resident declines such a meeting;

2. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:386 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9065. Health Care and Nursing Services

[Formerly §9081]

A. - C.16. ...

17. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the administrator, the Louisiana Board of Pharmacy, LDH Controlled Dangerous Substances Program and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

18. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:69 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:386 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9067. Delivery of Services

[Formerly §9083]

A. - B.6. ...

C. The services provided by the PRTF shall involve active treatment.

1. The team of professionals who shall develop the comprehensive plan of care shall be composed of physician(s) and other personnel who are employed by, or who provide services to the recipient in the facility. The team shall be capable of assessing the resident’s immediate and long-range therapeutic

needs, personal strengths and liabilities, potential resources of the resident’s family, capable of setting treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team shall include, at a minimum, either:

a. - c. ...

2. The team shall also include one of the following:

a. - d. ...

4. The comprehensive plan of care is a written plan developed for each recipient to improve the recipient’s condition to the extent that inpatient care is no longer necessary. The plan shall:

a. - c. ...

5. The plan shall be reviewed as needed, but at a minimum of every 30 days by the facility treatment team to determine that services being provided are, or were, required on an inpatient basis and recommend changes in the plan as indicated by the recipient’s overall adjustment as an inpatient.

D. - F. ...

1. The program shall be appropriate to the needs and interests of residents and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

D.2. - H.7. ...

I. Each resident shall have a minimum of one face-to-face contact with a psychiatrist each month and additional contacts for individuals from special risk populations, and as clinical needs of the resident dictate.

J. - J.8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:70 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:388 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter F. Physical Environment

§9077. Interior Space

[Formerly §9063]

A. - E. ...

1. Single rooms shall contain at least 80 square feet and multi-bed rooms shall contain at least 60 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment.

2. - 12. ...

13. Each resident shall have his/her own bed. A resident’s bed shall be longer than the resident is tall, no

less than 30 inches wide, of solid construction and shall have a clean, comfortable, nontoxic fire retardant mattress.

E.14. - N. ...

1. The provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of all residents.

2. ...

3. All gas heating units and water heaters shall be vented adequately to carry the products of combustion to the outside atmosphere. Vents shall be constructed and maintained to provide a continuous draft to the outside atmosphere in accordance with the recommended procedures of the American Gas Association Testing Laboratories, Inc.

4. All heating units shall be provided with a sufficient supply of outside air so as to support combustion without depletion of the air in the occupied room.

O. - Q.2. ...

3. Each room shall be for single occupancy and contain at least 60 square feet. It shall be constructed to prevent resident hiding, escape, injury or suicide.

R. - U. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:391 (February 2012), LR 39:2510 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter G. Emergency Preparedness

§9083. Safety and Emergency Preparedness

A. The PRTF shall incorporate an all hazards risk assessment into the facility's emergency preparedness plan designed to manage the consequences of medical emergencies, power failures, fire, natural disasters, declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the residents. The facility shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency.

B. - B.1. ...

2. The facility's plan shall be submitted to the parish or local Office of Homeland Security and Emergency Preparedness (OHSEP) yearly and upon request of either of these offices and verification of this submittal maintained in the plan. Any recommendations by the parish or local OHSEP regarding

the facility's plan shall be documented and addressed by the PRTF.

B.3. - N. ...

O. The facility's plan shall include how the PRTF will notify OHSEP and LDH when the decision is made to shelter in place and whose responsibility it is to provide this notification.

P. - P.6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:394 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9085. Emergency Plan Activation, Review, and Summary

A. ...

B. PRTFs shall conduct a minimum of 12 fire drills annually with at least one every three months on each shift. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disasters.

B.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:395 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9087. Notification of Evacuation, Relocation, or Temporary Cessation of Operations

A. - B. ...

C. In the event that a PRTF evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish OHSEP, the PRTF shall immediately give notice to the Health Standards Section, the Office of Behavioral Health (OBH), and OHSEP by facsimile or email of the following:

1. - 2. ...

D. In the event that a PRTF evacuates, temporarily relocates or temporarily ceases operations at its licensed location for any reason other than an evacuation order, the PRTF shall immediately give notice to the Health Standards Section by facsimile or email of the following:

1. - 2. ...

E. If there are any deviations or changes made to the locations of the residents that were given to the Health

Standards Section, OBH and OHSEP, then Health Standards, OBH, and OHSEP shall be notified of the changes within 48 hours of their occurrence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:396 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§9089. Authority to Re-Open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation

A. - F.7. ...

G. Inactivation of Licensure due to a Non-declared Disaster or Emergency

1. A PRTF in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

a. the PRTF shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

i. the PRTF has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

ii. the PRTF intends to resume operation as a PRTF agency in the same service area;

iii. the PRTF attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

iv. the PRTF's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility.

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

b. the PRTF 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

c. the PRTF continues to submit required documentation and information to the department, including but not limited to cost reports.

2. Upon receiving a completed written request to temporarily inactivate a PRTF license, the department shall issue a notice of inactivation of license to the PRTF.

3. Upon receipt of the department's approval of request to inactivate the agency's license, the PRTF shall have 90 days to submit plans for the repairs, renovations, rebuilding

or replacement of the facility, if applicable, to OSFM and OPH as required.

4. The PRTF shall resume operating as a PRTF in the same service area within one year of the approval of renovation/construction plans by the OSFM and the OPH as required.

EXCEPTION: If the PRTF requires an extension of this timeframe due to circumstances beyond the agency's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the agency's active efforts to complete construction or repairs and the reasons for request for extension of the agency's inactive license. Any approval for extension is at the sole discretion of the department.

5. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a PRTF 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:

a. the PRTF shall submit a written license reinstatement request to the licensing agency of the department;

b. the license reinstatement request shall inform the department of the anticipated date of opening and

shall request scheduling of a licensing or physical environment survey, where applicable; and

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

6. Upon receiving a completed written request to reinstate a PRTF license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

7. No change of ownership of the PRTF shall occur until such PRTF has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a PRTF facility.

8. The provisions of this Subsection shall not apply to a PRTF which has voluntarily surrendered its license and ceased operation.

9. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the PRTF license for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:396

(February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter H. Additional Requirements for Mental Health PRTFs

§9093. Personnel Qualifications, Responsibilities, and Requirements

A. A mental health PRTF shall have the following minimum personnel.

1. Administrator. The administrator shall have a Bachelor's degree from an accredited college or university in a mental health-related field, plus at least five years of related experience. The administrator is responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

1.a. - 2. ...

a. The clinical director shall be a physician holding an unrestricted license to practice medicine in Louisiana and who has the following:

i. ...

ii. if the license(s) is from another jurisdiction, the license(s) shall be documented in the employment record and shall also be unrestricted;

iii. ...

iv. satisfactory completion of a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director, which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If the training was completed in a psychiatric residency program not accredited by the ACGME, the physician shall demonstrate that he/she meets the most current requirements as set forth in the American Board of Psychiatry and Neurology's board policies, rules and regulations regarding information for applicants for initial certification in psychiatry.

2.b. - 7. ...

B. If the PRTF is providing both mental health and substance abuse treatment, the PRTF shall also meet the staffing requirements for the resident's ASAM level required by the department, or the department's designee, in addition to the mental health PRTF requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:397

(February 2012), amended LR 39:2511 (September 2013), LR 42:279 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter I. Additional Requirements for Addictive Disorder PRTFs

§9097. Personnel Qualifications, Responsibilities, and Requirements for Addictive Disorder PRTFs

A. An addictive disorder PRTF shall have the following minimum personnel:

1. Administrator. The administrator shall have a bachelor's degree from an accredited college or university in a mental health-related field, plus at least five years of related experience. The administrator is responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

a. Grandfathering Provision. For a facility with a current substance abuse license from LDH at the time of the promulgation of this final Rule, the current administrator may remain the administrator of the facility provided the following conditions are met.

1.a.i. - 2. ...

a. The clinical director shall be a physician holding an unrestricted license to practice medicine in Louisiana and who has the following:

i. ...

ii. if the license(s) is from another jurisdiction, the license(s) shall be documented in the employment record and shall also be unrestricted; and

iii. - iii.(b). ...

(c). an ABMS board-certified physician (non-psychiatrist) with ASAM certification and consultation with an ABPN board-certified psychiatrist. Proof of consultation shall be a current contract with a board-certified psychiatrist and written documentation of consults in the resident's medical record.

2.b. - 5.b. ...

6. Physician. The PRTF, except one that provides a social detoxification program only, shall have available a physician licensed in the state of Louisiana who shall assume 24-hour on-call medical responsibility for non-emergent physical needs of the facility's residents; the PRTF may have available, in place of the physician, a licensed advanced nurse practitioner who has a collaborative agreement with a physician or a physician's assistant who has a supervising physician and works under the licensed physician.

A.7. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:399 (February 2012), amended LR 39:2511 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Rebekah E. Gee MD, MPH

Secretary