RULE

Department of Health
Bureau of Health Services Financing

Emergency Telemedicine/Telehealth
(LAC 50:I.501, 503, and 505)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.Chapter 5 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 1. General Provisions

Chapter 5. Telemedicine/Telehealth

§501. Introduction

A. Telemedicine/telehealth is the use of an interactive audio and video telecommunications system to permit real time communication between a distant site health care practitioner and the beneficiary. There is no restriction on the originating site (i.e., where the beneficiary is located) and it can include, but is not limited to, a healthcare facility, school, or the beneficiary’s home.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2032 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 46:796 (June 2020), LR 48:

§503. Claim Submissions

A. Medicaid covered services provided via telemedicine/telehealth shall be identified on claim submissions by appending the appropriate place of service or modifier to the appropriate procedure code, in line with current policy.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2032 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 45:436 (March 2019), LR 48:

§505. Emergency Provisions

A. In the event that the federal or state government declares an emergency or disaster, the Medicaid Program may temporarily cover services provided through the use of an interactive audio telecommunications system, without the

requirement of video, if such action is deemed necessary to ensure sufficient services are available to meet beneficiaries' needs.

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 48:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Home Health Agencies
Licensing Standards
(LAC 48:I.Chapter 91)

The Department of Health, Bureau of Health Services Financing proposes has amended LAC 48:I.Chapter 91 as authorized by R.S. 36:254 and R.S. 40:2116.31 et seq. This proposed 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 and Certification

Chapter 91. Minimum Standards for Home Health Agencies

§9101. Definitions

A. The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Abuse—

a. the willful infliction of physical or mental injury;

b. causing deterioration by means including, but not limited to:

i. sexual abuse;

ii. exploration; or

iii. extortion of funds or other things of value to such an extent that the health, moral or emotional well-being of the individual being supported is endangered; or

c. the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in or which could reasonably be expected to result in physical or mental harm, pain or mental anguish. Lack of awareness or knowledge by the victim of the act which produced, or which could have reasonably been expected to produce, physical or mental injury or harm shall not be a defense to the charge of abuse.

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Advanced Practice Registered Nurse (APRN)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certificates.

Advisory Board—Repealed.

Allied Health Personnel—nursing assistants, licensed practical nurses, licensed physical therapy assistants, and other health care workers who require supervision by other licensed health care professionals in accordance with their scope of practice.

Branch—an office from which a home health agency (HHA) provides services within a portion of the total geographic service area served by the parent agency. The branch office is part of the parent HHA; is located within a 50-mile radius of the parent agency; and shares administration and supervision.

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

Change of Ownership (CHOW)—the addition, substitution, or removal, whether by sale, transfer, lease, gift, or otherwise, of a licensed health care provider subject to this Rule by a person, corporation, or other equity, which results in a change of controlling interest of assets or other equity interests of the licensed entity may constitute a CHOW of the licensed entity.

a – d. Repealed.

Clinical Manager—a person designated in writing to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and be responsible for compliance with regulatory requirements.

Clinical Note—a written or electronic notation of each visit with a patient, which shall include the date and time of the visit, services rendered, and the signature of person

providing services. The note shall include any pertinent information related to the visit.

Clinical Nurse Specialist (CNS)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Clinical Records—those documents maintained on all patients accepted for care by an HHA. The records shall be retained in accordance with existing state laws.

Controlling Ownership or Controlling Interest—an equity or voting interest possessed by a person or entity that:

a. has a direct or indirect equity interest equal to 5 percent or more in the capital, the stock, or the profits of an HHA; or

b. is an officer or director of an HHA which is organized as a corporation; or

c. is a partner in an HHA which is organized as a partnership; or

d. is a member or manager of an HHA which is organized as a limited liability company. The term controlling ownership is synonymous with the terms controlling interest or control interest as defined by the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS).

Department—the Department of Health (LDH) or any of its sections, bureaus, offices or its contracted designee.

Director of Nurses (DoN)—Repealed.

Employed—being assigned the performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired for a staff position.

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Governing Body—the person or group of persons who have legal authority for and/or ownership of the corporation of the HHA and responsibility for agency operations. A governing body assumes full legal authority and responsibility for the operation of the agency.

Home Health Agency—a state-owned and operated agency, or a subdivision of such an agency or organization; or a private nonprofit organization; or a proprietary organization which provides skilled home health care and support services to the public. Skilled home health care is provided under the order of an authorized healthcare provider, in the place of residence of the person receiving the care, and includes skilled nursing and at least one of the following services:

a. physical therapy;

b. speech therapy;

c. occupational therapy;

d. medical social services; or

e. home health aide services.

Home Health Agency Premises—the physical site where the HHA maintains staff to perform administrative functions, and maintains its personnel records, or maintains its patient service records, or holds itself out to the public as being a location for receipt of patient referrals. The HHA shall be a separate entity from any other entity, business, or trade. If office space is shared with another healthcare related entity, the HHA shall operate independently, have a clearly defined scope of services, and ensure confidentiality is maintained for the HHA's patients. The HHA may not share office space with a non-healthcare related entity.

Home Health Aide—a person qualified to provide direct patient care in the home under the supervision of a RN or physical therapist to assist the patient with ADLs, in accordance with a written plan of care (POC), and requiring a clinical note for each patient visit.

Home Health Licensure Forms—the collection of appropriate forms for licensure that may be obtained from the department's website. Home health licensure forms shall be completed by all initial applicants before the licensure process can begin.

Jurisdiction—all home health agencies shall be under the jurisdiction of the LDH, which promulgates and enforces the rules governing the operation of such agencies or organizations. However, nothing in this Part shall be construed to prohibit the delivery of personal care, homemaker, respite, and other in-home services by a person or entity not licensed under this Rule unless provided with other home health services.

Licensed Practical Nurse—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications and who works under the supervision of an RN.

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Misappropriation—taking possession without the permission of the individual who owns the personal belongings or the deliberate misplacement, exploitation or wrongful temporary or permanent use of an individual's belongings or money without the individual's consent.

Neglect—the failure by a caregiver responsible for an individual's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being, unless the patient exercises his/her right to refuse the necessary care.

Non-Licensed Person—any person who provides health-related services for compensation directly related to patient

care to patients of an HHA and who is not a licensed healthcare provider. A non-licensed person is also any person who provides such services to individuals in their own homes as an employee or contract provider of an HHA.

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

Nurse Practitioner (NP)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Physician—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Physician Assistant (PA)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

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Registered Nurse—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

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Support Services—Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2239 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9102. Governing Body

A. The governing body shall designate an individual who is responsible for the day-to-day management of the HHA and shall ensure that all services provided are consistent with accepted standards of practice.

B. Responsibilities. The governing body shall:

1. conduct an annual documented review of the policies and procedures, the budget, overall program evaluation, statistical information, complaint resolutions, any projected changes, and emergency preparedness;

2. maintain written minutes of meetings with the signatures of all attendees, dates, and times; and

3. receive written notification of any of the following:

a. the agency’s administrator or clinical manager is fired, resigns, or becomes incapacitated to the extent that he/she can no longer perform his/her duties;

b. the agency is surveyed and found to be in violation of the state law, minimum standards, Rules, or regulations of LDH;

c. any other grounds which adversely affect the agency’s operation;

4. shall receive and acknowledge the results of any QAPI evaluation; and

5. maintain an organizational chart that delineates lines of authority and responsibility for all home health personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

§9103. Personnel Qualifications and Responsibilities

A. Administrator. The administrator shall be appointed by and answer directly to the governing body of the agency. The administrator of the agency shall be designated in writing. The administrator shall be administratively responsible and available in person or by telecommunication at all times for all aspects of facility operation. The administrator and the clinical manager or the alternate clinical manager may be the same individual if dually qualified. If an individual is designated as the administrator for more than one agency, then

he/she shall designate an alternate who is a full-time, on-site employee of each agency and meets the qualifications for an administrator.

1. Qualifications

a. The administrator shall have three years of management experience in the delivery of health care service and meet one of the following criteria:

i. is a licensed physician; or

ii. is an RN; or

iii. is employed as an administrator on or after January 13, 2018, and is a college graduate with a bachelor's degree; or

iv. is employed as an administrator prior to January 13, 2018, and has had three additional years of documented experience in health care delivery service; or

v. is an administrator who has experience in health service administration with at least one year of supervisory or administrative experience related to home health care or a home health care program.

vi. Repealed.

b. Repealed.

2. Responsibilities. The administrator shall:

a. – f. ...

g. act as liaison between staff, the group of professional personnel, and the governing body;

h. implement an ongoing accurate and effective budgeting and accounting system; and

i. ensure that complaints reported by patients, families, caregivers, authorized healthcare providers, agency staff or public are investigated and addressed in a timely manner.

3. Continuing Education. The administrator shall annually obtain two continuing education hours relative to the administrator’s role, which may include, but not be limited to the following topics:

a. Medicare and Medicaid regulations;

b. management practices;

c. labor laws;

d. Occupational Safety and Health Administration rules, laws, etc.;

e. ethics; and

f. quality improvement.

B. Clinical Manager

1. Qualifications. The clinical manager shall be an RN who is currently licensed to practice in the state of Louisiana and has at least three years of experience as an RN. One of these years shall consist of full-time experience in

providing direct patient care in a home health setting. The clinical manager shall be a full-time employee of the licensed HHA and shall not work full-time at any other licensed healthcare agency. The clinical manager shall be available at all times during operating hours and additionally as needed.

NOTE: The clinical manager may not work for another licensed healthcare entity when on call or during operating hours of the HHA.

a. – b. Repealed.

2. Responsibilities. The clinical manager shall:

a. be a full-time employee of only one HHA;

b. supervise all patient care activities to assure compliance with current standards of accepted nursing practice;

c. establish personnel and employment policies to assure that only qualified personnel are hired; employ qualified personnel by verifying licensure and/or certification (as required by law) prior to employment and annually thereafter; and certify and maintain records to support competency of all allied health personnel;

i. – iii. Repealed.

d. develop and maintain agency policy and procedure manuals that establish and support the highest possible quality of patient care, cost controls, quality

assurance, and mechanisms for disciplinary action for infractions;

e. supervise employee health program;

f. assure compliance with local, state, and federal laws as well as promote the health and safety of employees, patients and the community with the following non-exclusive methods:

i. resolve problems;

ii. perform complaint investigations;

iii. refer impaired personnel to proper authorities;

iv. provide for orientation and in-service to personnel to promote the health and safety of the patient as well as to familiarize staff with regulatory issues and agency policy and procedures;

v. ensure orientation of health care personnel who provide direct patient care;

vi. ensure timely annual evaluation of health care personnel;

vii. assure regularly scheduled appropriate continuing education for all health professionals and home health aides;

viii. assure that the care provided by the health care personnel promotes the health and safety of the patient; and

ix. assure that agency policies are enforced, including but not limited to checking the direct service worker (DSW)/certified nurse aide (CNA) registry for adverse actions against non-licensed employees in accordance with state laws;

g. be on site or immediately available to be on site and available by telecommunications during normal operating hours. The agency shall designate in writing an RN who shall assume the responsibilities of the clinical manager during his/her absence, i.e., on vacation, ill time, at a workshop, etc.

3. Continuing Education. The clinical manager shall annually obtain two continuing education hours relative to the clinical manager’s role, which may include, but not be limited to the following topics:

a. Medicare and Medicaid regulations;

b. management practices;

c. labor laws;

d. Occupational Safety and Health Administration rules, laws, etc.;

e. ethics; and

f. quality improvement.

C. Home Health Aide

1. Qualifications. A home health aide shall meet the following criteria:

a. have current nursing assistant certification and successfully complete the agency’s competency evaluation; or

b. have successfully completed a home health aide training program and successfully complete the agency’s competency evaluation and meet each of the following:

i. exhibit a sympathetic attitude toward the patient, an ability to provide care to the sick, and the maturity and ability to deal effectively with the demands of the job;

ii. have the ability to read, write, and carry out directions promptly and accurately; and

iii. shall inform all employers when employed with one or more agencies; cooperate and coordinate to assure highest performance of quality when providing services to the patient.

NOTE: Repealed.

2. Responsibilities. The home health aide:

a. shall obtain and record vital signs during each visit in addition to notifying the primary RN of deviations according to standard practice;

b. may provide assistance with the following ADL’s during each visit: mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting. Some examples of assistance include:

i. helping the patient with a bath, care of the mouth, skin and hair;

ii. helping the patient to the bathroom or in using a bed pan or urinal;

iii. helping the patient to dress and/or undress;

iv. helping the patient in and out of bed, assisting with ambulation;

v. helping the patient with prescribed exercises which the patient and the health aide have been taught by appropriate personnel; and

vi. performing such incidental household services essential to the patient’s health care at home that are necessary to prevent or postpone institutionalization;

c. may perform care assigned by an RN if the delegation is in compliance with current standards of nursing practice;

d. may administer over the counter disposable enemas, saline or vinegar douches, and glycerine or Ducolax suppositories if such are included in the patient’s POC; and

e. shall complete a clinical note for each visit, which shall be incorporated into record at least on a weekly basis.

f. – g. Repealed.

3. Restrictions. The home health aide shall not:

a. perform any intravenous procedures, procedures involving insertion of feeding tubes or urinary catheters, the administration of tube feedings, or any other sterile or invasive procedures;

b. administer medications to any patient; and

c. perform any of the following tasks which are not home health aide services:

i. transporting the patient;

ii. general housekeeping duties; or

iii. shopping.

4. Training. An HHA that offers a training program shall, at a minimum, include the following in the training program:

a. communication skills;

b. observation, reporting and documentation of patient status and the care or service furnished;

c. reading and recording temperature, pulse, and respiration;

d. basic infection control procedures;

e. basic elements of body functioning and changes in body function that shall be reported to the patient's RN;

f. maintenance of a clean, safe, and healthy environment of the patient's immediate surroundings;

g. recognizing emergencies and knowledge of emergency procedures;

h. the physical, emotional, and developmental needs of the patient and methods for working with the populations served by the agency, including the need to respect the patient, his/her privacy and his/her property;

i. safe transfer techniques and ambulation;

j. appropriate and safe techniques in personal hygiene and grooming that include:

i. bed bath;

ii. sponge, tub, or shower bath;

iii. sink, tub, or bed shampoo;

iv. nail and skin care;

v. oral hygiene; and

vi. toileting and elimination.

k. normal range of motion and positioning;

l. adequate nutrition and fluid intake;

m. any other task, within state regulations, that the agency may choose to have the home health aide perform.

5. Orientation. The content of the basic orientation provided to home health aides shall include the following:

a. policies and objectives of the agency;

b. duties and responsibilities of a home health aide;

c. the role of the home health aide as a member of the health care team;

d. ethics and confidentiality;

e. record keeping;

f. information on the process of aging and behavior of the aged;

g. information on the emotional problems accompanying illness; and

h. principles and practices of maintaining a clean, healthy and safe environment.

6. Assignment. The home health aide is assigned to a patient by an RN in accordance with the POC. Specific written instructions for patient care are prepared by an RN or therapist as appropriate. All personal care services are described to the patient, in writing, by the RN in charge of that patient.

7. Supervision. An RN or licensed therapist shall provide direct supervision to the home health aide as follows.

a. An RN shall supervise and evaluate the home health aide's ability to perform assigned duties, relate to the

patient, and work effectively as a member of the health care team.

b. Periodic on-site supervision with the home health aide present shall be established as part of the agency's policies and procedures.

c. If the patient is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech language pathology), the supervisory visits shall be made to the patient's residence at least once every two weeks (not to exceed 14 days) by the RN or appropriate therapist to assess relationships and determine whether goals are being met.

d. If the patient is not receiving skilled services, an RN shall make a supervisory visit to the patient's residence at least once every 60 days. In order to ensure that the aide is properly caring for the patient, the supervisory visit shall occur while the home health aide is providing patient care.

e. Documentation of supervision shall include the aide-patient relationships, services provided, and instructions and comments given as well as other requirements of the clinical note.

f. Annual performance review for each aide shall be documented in the individual's personnel record.

8. In-service. The agency shall offer a minimum of 12 hours of appropriate in-service training to each home health aide every calendar year. The in-service may be furnished while the aide is providing service to the patient, but shall be documented.

a. These in-service sessions should include, but are not limited to:

i. care of the body;

ii. communication;

iii. infection control;

iv. safety and documentation.

b. In-service training may be prorated for employees who only worked a portion of the year; however, part-time employees who work throughout the year shall attend 12 hours of in-service training.

c. Documentation should include the outline and length of the in-service training.

D. Licensed Practical Nurse

1. Qualifications. A licensed practical nurse (LPN) shall:

a. be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions;

b. have worked at least one year as an LPN prior to being employed by an HHA; and

c. inform all employers when employed with one or more agencies and cooperate and coordinate to assure highest performance of quality when providing services to the patient.

d. – f. Repealed.

2. Responsibilities. The LPN shall:

a. perform skilled nursing services under the supervision of an RN in accordance with the laws governing the practice of practical nursing;

b. observe and report the patient’s response to treatment and any changes in the patient’s condition to the authorized healthcare provider and the supervising RN;

i. – vi. Repealed.

c. administer prescribed medications and treatments as permitted by the laws governing the practice of practical nursing;

d. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

e. perform wound care as ordered in accordance with the POC; and

f. perform routine venipuncture (phlebotomy) if written documentation of competency is in personnel record. Competency shall be evaluated by an RN even if LPN has completed a certification course.

3. Restrictions. The LPN shall not:

a. access any intravenous appliance for any reason;

b. perform supervisory visit for a home health aide;

c. develop and/or alter the POC;

i. – iii. Repealed.

d. make initial assessment visit;

e. prepare the recertification;

f. make aide assignments; or

g. function as a supervisor of the nursing practice of any RN.

4. – 8.c. Repealed.

E. Medical Social Services

1. Qualifications. A medical social worker shall:

a. be currently licensed by the Louisiana Board of Certified Social Work Examiners; or

b. have a master’s degree from a school of social work accredited by the Council on Social Work Education in accordance with the requirements of the Louisiana State Board of Social Work Examiners.

c. Repealed.

2. Responsibilities. The medical social worker shall:

a. assist the authorized healthcare provider and other members of the health care team in understanding significant social and emotional factors related to the patient’s health problems;

b. assess the social and emotional factors having an impact on the patient's health status, and assist in the formulation of the POC;

c. provide services within the scope of practice, as defined by state law, in accordance with the POC and in coordination with other members of the health care team;

d. ...

e. participate in discharge planning and in-service programs related to the needs of the patient; acts as a consultant to other members of the health care team; and

f. prepare a written assessment and summary of services provided when medical social work services are discontinued, including an assessment of the patient’s current status that shall be retained in the patient’s clinical record, and a copy forwarded to the attending authorized healthcare provider within five business days.

3. Restrictions. An unlicensed medical social worker may not contract directly with the HHA for clinical services, consultation, supervision or educational services.

a – g. Repealed.

F. Nutritional Guidance Services

1. Qualifications. If an agency provides or arranges for nutritional guidance, the staff member or consultant shall be a professional dietitian who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

a. – b. Repealed.

2. Responsibilities. The dietitian shall:

a. document each visit made to the patient and incorporate notes into the clinical record on a weekly basis;

b. prepare initial nutritional dietary assessment;

c. communicate with the clinical manager, the nurse supervisor and/or the primary nurse assigned to the patient regarding the need for a continuation of services for each patient;

d. evaluate compliance with authorized healthcare provider ordered therapeutic diet and makes recommendations as needed;

e. evaluate patient’s socio-economic factors to develop recommendations concerning food purchasing, preparation and storage;

f. train those persons who are responsible for purchasing and storing food;

g. evaluate food preparation methods to ensure that nutritive value is conserved in addition to flavor, texture and temperature principles being adhered to in meeting the individual patient’s needs;

h. participate in all related case conferences with agency staff. Minutes of case conferences are retained in patient’s clinical record;

i. prepare a written discharge summary and ensure that a copy is retained in patient’s clinical record and a copy is forwarded to the attending authorized healthcare provider within five business days;

j. assess and evaluate the food and nutritional needs of the patient in accordance with the plan of treatment and the recommended daily dietary allowances established by the Food and Nutrition Board, National Academy of Sciences-National Research Council;

k. participate in discharge planning and in-service training programs related to the needs of the patient and acts as a consultant to the other members of the health care team; and

l. ensure that a current diet manual (within five years of publication) is readily available to agency staff where applicable.

3. Repealed.

G. Occupational Therapist

1. Qualifications. An occupational therapist shall be currently licensed by the LSBME.

2. Responsibilities. The occupational therapist shall:

a. assist the authorized healthcare provider in evaluating the patient’s functional status and occupational therapy needs, and assist in the development of the POC;

b. provide services within the scope of practice as defined by the state laws governing the practice of occupational therapy, in accordance with the POC, and in coordination with other members of the health care team;

c. observe and report the patient’s response to treatment and any changes in his/her condition to the authorized healthcare provider and the supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when occupational therapy services are discontinued, prepare a written discharge summary of services

provided, including an assessment of patient’s current status, for retention in the patient’s clinical record, and forward a copy to the attending authorized healthcare provider within five business days; and

g. provide supervision of the occupational therapy assistant (OTA) as follows:

i. be readily available to the OTA by telecommunications;

ii. assess the competency and experience of the OTA;

iii. establish the type, degree and frequency of supervision that is required for an OTA in a home health setting; and

iv. conduct a face-to-face patient care conference with each OTA once every two weeks, or once every four to six treatment sessions, to review progress and modification of treatment programs for all patients.

h. – l. Repealed.

H. Occupational Therapy Assistant

1. Qualifications. The OTA shall:

a. be currently licensed by the Louisiana State Board of Medical Examiners to assist in the practice of occupational therapy under the supervision of a licensed registered occupational therapist; and

b. have, at a minimum, two years’ experience as a licensed OTA before starting a home health caseload.

2 – 2.g.iv. Repealed.

I. Physical Therapist

1. Qualifications. The physical therapist shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners.

a – b. Repealed.

2. Responsibilities. The physical therapist shall:

a. assist the authorized healthcare provider in evaluating the patient’s functional status and physical therapy needs, and assist in the development of the POC;

b. provide services within the scope of practice as defined by the state laws governing the practice of physical therapy, in accordance with the POC, and in coordination with other members of the health care team;

c. observe and report the patient’s reaction to treatment and any changes in his/her condition to the authorized healthcare provider and the supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when physical therapy services are discontinued, prepare a written discharge summary and ensure that a copy is retained in the patient’s clinical record and a copy is forwarded to the attending authorized health care provider;

g. may supervise home health aides in lieu of an RN if physical therapy is the only skilled service being provided;

h. provide supervision to a physical therapy assistant (PTA) as follows:

i. be readily accessible by telecommunications;

ii. evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program;

iii. treat and reassess the patient on at least every sixth visit, but not less than once per month;

iv. conduct a face-to-face patient care conference every two weeks with each PTA to review progress and modification of treatment programs for all patients; and

v. assess the final treatment rendered to the patient at discharge and include in the discharge summary.

J. Physical Therapy Assistant

1. Qualifications. The PTA shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners and be supervised by a licensed physical therapist. The PTA shall have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

a. – c. Repealed.

2. Restrictions. The PTA’s duties shall not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination or major modifications of treatment programs.

a. – h.v. Repealed.

K. Registered Nurse

1. Qualifications. The RN shall be currently licensed by the LSBN without restrictions and have, at a minimum, one year of clinical experience as an RN. This requirement may be waived for an RN with one year’s clinical experience as an LPN.

a. Special Qualifications. In addition to the above qualifications, an RN shall have one of the following credentials in order to provide psychiatric nursing services.

Work experience shall have been obtained within the last five years. If experience is not within the five-year time period, then documentation shall be provided to support either psychiatric retraining, classes, or CEUs to update psychiatric knowledge:

i. a master’s degree in psychiatric or mental health nursing; or

ii. a bachelor’s degree in nursing and one year of work experience in an active treatment unit in a psychiatric or mental health facility or outpatient mental health clinic; or

iii. a diploma or associate degree and two years of work experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

2. Responsibilities. The RN shall:

a. provide or supervise skilled nursing services in accordance with authorized healthcare provider orders;

b. assess and regularly re-evaluate the nursing needs of the patient;

c. develop, initiate, implement, and update the POC as needed or at least every 60 days, or as needed;

d. provide specialized nursing services, which may include treatments and diagnostic and preventive procedures;

e. initiate preventive and rehabilitative nursing procedures as appropriate for the patient’s care and safety;

f. coordinate services and inform the authorized healthcare provider and other personnel of changes in the patient’s condition and needs;

g. teach, supervise and counsel the patient, family members and other members of the health care team regarding the nursing care needs and other related problems of the patient at home;

h. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

i. observe and report the patient’s response to treatment and any changes in his/her condition to the authorized healthcare provider and supervising RN;

j. conduct on-site supervisory evaluations at least every six months of each licensed practical nurse while he/she is providing care and document such supervision in the LPN’s personnel file;

k. conduct on-site supervision of patient care provided by the home health aide; and

l. function as patient advocate in all medical decisions affecting the patient.

3. Restrictions. An RN applicant may not work in the home health setting as an RN.

L. Speech Pathology Services

1. Qualifications. The speech pathologist shall be currently licensed by the Louisiana Board of Examiners of Speech Pathology and Audiology.

a. – a.iii. Repealed.

2. Responsibilities. The speech pathologist shall:

a. assist the authorized healthcare provider and other members of the health care team in evaluating the patient’s speech or language needs and formulating the POC;

b. provide service within the scope of practice as defined by the state law governing the practice of speech pathology, in accordance with the POC and in coordination with other members of the health care team;

c. observe and report the patient’s response to treatment and any changes in the patient’s condition to the authorized healthcare provider and supervising RN;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the POC, functional limitations and progress towards goals;

e. prepare clinical and or progress notes for each visit and incorporate them into the clinical record at least weekly; and

f. prepare a written summary of the services provided when speech therapy services are discontinued, including an assessment of the patient's current status which shall be retained in the patient's clinical record and a copy forwarded to the authorized healthcare provider within five business days.

2.g. – M.2.f. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq..

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2240 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9105. State Licensure

A. Initial Licensure

1. The LDH is the only licensing authority for home health agencies in the state of Louisiana. To initiate the review process for licensure as an HHA, the applicant shall submit the following:

a. ...

b. the required fee for licensure by corporate check, certified check or money order or in other manner as determined by the department. This fee is non-refundable;

c. ...

d. proof of general and professional liability insurance as well as worker's compensation insurance. The general and professional liability coverage shall be for at least $300,000. The agency shall maintain these insurance requirements at all times, and be able to provide proof of insurance upon request as follows:

i. proof of general liability insurance of at least $300,000 per occurrence;

ii. proof of worker’s compensation insurance as required by state law;

iii. proof of professional liability insurance of at least $100,000 per occurrence/$300,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient’s Compensation Fund (PCF):

(a). if the HHA is self-insured and is not enrolled in the PCF, professional liability limits shall be $1 million per occurrence/$3 million per annual aggregate.

NOTE: The LDH-Health Standards Section (HSS) shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent);

e. résumés and documentation of qualifications for administrator and clinical manager. Additional information may not be submitted after the original resumé is submitted for review, except for changes in the designated positions or with approval of the HSS;

f. – g. ...

h. proof of citizenship or a valid green card for all administrative personnel, officers, directors and owners;

i. any other forms for initial licensure as required by the HSS; and

j. the “doing business as” (DBA) name of the agency shall not be the same or similar to another licensed HHA registered with the Secretary of State.

2. An application shall not be reviewed until payment of application fee has been received. All requirements of the application process shall be completed by the applicant within 90 days of the date of the initial submission of the home health license application. Upon approval of the application by LDH, the applicant shall agree to become fully operational and

prepared for initial survey within 90 days. Any application not completed within 90 days after the initial submission shall be closed.

3. The applicant shall be notified in writing when the application process is completed and the application is approved. The applicant shall receive instructions regarding requesting an initial licensing survey.

4. Approved applicants shall be fully operational, in compliance with all licensing standards and providing care to only two patients at the time of the initial survey.

5. Repealed.

B. Types of Licenses. The LDH shall have the authority to issue the three types of licenses described below:

1. ...

2. Provisional License—may be issued to those existing agencies that do not meet criteria for full licensure. Such licenses may be issued to any agency by the department when the agency:

a. receives more than five violations of the minimum standards in a one-year period;

b. receives more than three valid complaints in a one-year period;

c. has placed a patient at risk according to a documented incident;

d. fails to correct deficiencies within 60 days of being cited;

e. fails to submit assessed fees after notification by the department;

f. has an owner, administrator, officer, director or clinical manager who has pled guilty or nolo contendere to a felony, or been convicted of a felony as documented by a certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a provisional license may also be issued when any of the members, officers, or the person designated to manage or supervise the agency has been convicted of a felony; or

g. fails to notify the department in writing within 30 days of the occurrence of a change in any of the following:

i. controlling ownership;

ii. administrator;

iii. clinical manager or alternate;

iv. address/telephone number, either parent or branch;

v. hours of operation; and

vi. after-hours contact procedures.

C. – D. ...

E. Survey Process

1. Initial. An on-site survey shall be conducted to assure compliance with the minimum standards. The request for initial licensing survey shall be accepted after the applicant has been notified in writing by the department that the application process is completed and the applicant is approved for an initial survey. This survey shall be unannounced and the agency shall have only one opportunity to be in compliance with the minimum standards. If the initial survey finds that the agency is not in substantial compliance with the minimum standards, then the agency shall transfer all patients and close.

2. Renewal. An unannounced, on-site visit may be conducted to assure compliance with the minimum standards as determined by the department. This survey may be conducted in conjunction with a survey for Medicare recertification or other reasons.

3. Follow-up. An unannounced survey may be conducted following annual re-licensing, complaint, or previous follow-up survey when the agency is not in substantial compliance with the minimum standards.

4. Complaint Investigation. The LDH has the authority to conduct investigations regarding home health agencies. A complaint investigation may be conducted during an

unannounced on-site visit, by administrative review, or by telephone, as appropriate.

5. Violations of Minimum Standards. If the agency is found to be in violation of the minimum standards during any survey, a statement of deficiencies listing those violations shall be issued to the agency. The agency shall respond to these violations with an acceptable plan of correction, which shall be submitted to the department. The plan of correction shall be received by the department within 10 days of receipt of the statement of deficiencies by the agency. A follow-up survey may be conducted to assure that the agency has achieved substantial compliance with the minimum standards. If the follow-up survey reveals that the agency is still not in substantial compliance with the minimum standards, then a provisional license may be issued or a revocation action may be initiated in accordance with R.S.40:2116.32 and R.S. 40:2116.36.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2245 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9107. Fees

A. Licensing Fee. A licensing fee, in the amount determined by LDH, is required to be submitted with the initial application. The department shall not consider an application as complete without the required licensing fee.

B. – C. ...

D. Change of Ownership Fee. A fee equal to the amount of licensing fee is to be paid to the department by the new owner when a CHOW occurs.

E. ...

F. Provisional License Fee. Any agency issued a provisional license shall pay an additional amount equal to the annual fee for each follow-up survey. Fees shall be paid to the department prior to the survey being performed and shall be non-refundable.

NOTE: All fees submitted to the department shall be in the form of a certified check, company check, or money order or in other manner as determined by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2246 (December 2001), amended by the

Department of Health, Bureau of Health Services Financing, LR 48:

§9109. Changes

A. Notice of Changes. The department shall be notified in writing by mail/e-mail or by facsimile no later than five days prior to the occurrence of any of the following changes:

1. – 6. ...

7. administrator or clinical manager;

8. controlling ownership; and

9. ...

B. Change of Ownership. The department shall be notified in writing of a CHOW or change of controlling interest.

1. A CHOW packet is required to be submitted with required fees.

2. When a change in controlling interest occurs, written documentation and disclosure of the change shall be submitted.

3. The purchaser of the agency shall meet all criteria for an initial application for licensure. (See §9105, State Licensure.)

C. Voluntary Termination of License. If at any time the agency ceases to operate, the agency shall meet the requirements of §9110.

D. Relocation of an Agency. The department shall be notified in writing of any relocation of an agency. An agency may only relocate within a 50-mile radius of the location where the agency was originally licensed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2246 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9110. Cessation of Business

A. Except as provided in §9116 and §9117 of these licensing regulations, a license shall be immediately null and void if an HHA becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the HHA ceases offering or providing services to the community and/or is considered non-operational in accordance with the requirements in §9115.B.1-3.c.

C. Upon the cessation of business, the HHA shall immediately return the original license to the department.

D. Cessation of business is deemed to be voluntary action on the part of the agency. The HHA does not have a right to appeal a cessation of business.

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

1. give 30 days' advance written notice to:

a. each patient or patient's legal representative, if applicable;

b. each patient's authorized healthcare provider; and

c. Health Standards Section.

2. provide for a safe and orderly discharge and transition of all of the HHA's patients.

F. In addition to the advance notice, the HHA shall submit a written plan for the disposition of patient related records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed agency's patient related records;

3. the name and contact information for the appointed custodian(s) who shall provide the following:

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

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing agency, at least 15 days prior to the effective date of closure.

G. If an HHA fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning an HHA for a period of two years.

H. Once any HHA has ceased doing business, the agency shall not provide services until the agency has obtained a new initial HHA license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

§9111. Denial, Revocation or Denial of License Renewal

A. Denial of Licensure Applications. If an agency's license is revoked or denied renewal, no other HHA license

application shall be accepted from that agency for approval by the department for two years from the date of the revocation or denial of renewal of the license.

B. Grounds for Denial or Revocation of License. The LDH may deny an application for a license, refuse to renew a license or revoke a license in accordance with R.S. 40:2116.36 and 40:2116.37.

C. Grounds for Immediate Denial or Revocation. A license shall be immediately denied or revoked if the department determines that the agency either knowingly and willfully or through gross negligence allowed or directed actions which resulted in:

1. – 2. ...

3. failure to protect patients or persons in the community from the harmful actions of the agency employees including, but not limited to coercion, threat, intimidation, solicitation and harassment;

4. – 6. ...

7. bribery, harassment, or intimidation of any person designed to cause that person to use the services of any particular HHA;

8. pleading guilty or nolo contendere to a felony, or being convicted of a felony by an owner, administrator, officer, director, or clinical manager as documented by a

certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a license may also be immediately denied or revoked when any of its members, officers, or the person designated to manage or supervise the home care has been convicted of a felony. For purposes of this Paragraph, conviction of a felony means and includes:

a. – c. ...

D. Additional Grounds for Denial or Revocation. A license may be denied, revoked or not renewed for failure to correct any violation of law and regulation for which a provisional license may have been issued under R.S. 40:2116.31, et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2247 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9113. Informal Dispute Resolution Process, Notice and Appeal Procedure

A. Informal Dispute Resolution Process. An agency has one opportunity to question citations of deficient practice through an informal dispute resolution process. To request an informal

dispute resolution discussion, the agency shall submit a written request specifying the deficient practice(s) that are being disputed and why the agency is questioning the deficient practice(s). The request shall be made within 10 calendar days of the date of the agency's receipt of the notice of the deficient practice(s). Reconsideration shall be made solely on the survey report, statement of violations and all documentation the agency submits to the department at the time of its request for reconsideration. Correction of a violation shall not be a basis for reconsideration. Since this is an informal dispute resolution discussion, it is not necessary for the agency's attorney to be present. However, if the agency wishes to include their attorney in the informal dispute resolution discussion, the agency shall indicate this in their written request. The informal dispute resolution process is not in lieu of the appeals process.

B. Notice. Notice of reasons for denial of renewal or revocation of a license shall be given in accordance with the current Louisiana Revised Statutes.

C. Administrative Appeal Process. When an administrative appeal is requested in a timely manner, the Division of Administrative Law (DAL) shall provide an administrative hearing in accordance with the provisions of the Louisiana

Administrative Procedure Act (APA) and the current Louisiana Revised Statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2247 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9115. Agency Operations

A. ...

B. Operational Requirements

1. An HHA shall:

a. – b. ...

c. have an RN immediately available by telecommunications at all times;

d. respond to patient care needs and authorized healthcare provider orders in a timely manner;

e. – i. ...

j. accept medical orders only from an authorized healthcare provider or authorized healthcare provider representative (e.g., hospital discharge planner);

k. ...

l. have an emergency preparedness plan (which conforms to the Louisiana Model Home Health Emergency Preparedness Plan) designed to manage the consequences of natural disasters or other emergencies that disrupt the HHA’s ability to provide home health services;

m. – q. ...

r. notify the department of any change of address, services added or ceased, and change of all key employees in accordance with §9109;

s. maintain general and professional liability insurance and workers' compensation insurance in accordance with the requirements of §9105.

2. An HHA may:

a. – b. ...

3. An HAA shall not:

a. – c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9116 Inactivation of License Due to a Declared Disaster or Emergency

A. An HHA licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S.29:724 or R.S.29:766, may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed agency shall submit written notification to the HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the agency has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed agency intends to resume operation as an HHA in the same service area;

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

d. includes an attestation that all patients have been properly discharged or transferred to another provider; and

e. provides a list of each patient and where that patient is discharged or transferred to;

2. the licensed agency resumes operating as an HHA in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed HHA 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

4. the licensed HHA continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate an HHA license, the department shall issue a notice of inactivation of license to the HHA.

C. Upon completion of repairs, renovation, rebuilding or replacement, an HHA which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The HHA shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The agency resumes operating as an HHA in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766.

D. Upon receiving a completed written request to reinstate an HHA license, the department shall conduct a licensing survey. If the HHA meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the HHA license.

E. No CHOW in the HHA shall occur until such HHA has completed repairs, renovations, rebuilding or replacement construction, and the HHA has reinstated its license and resumed operation as an HHA.

F. The provisions of this Section shall not apply to an HHA which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HHA license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9117. Inactivation of License Due to a Non-Declared Disaster or Emergency

A. A licensed HHA 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:

1. The licensed HHA shall submit written notification to the HSS within 30 days of the date of the non-declared emergency or disaster stating that:

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

b. the licensed HHA intends to resume operation as a HHA in the same service area;

c. the licensed HAA attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the licensed HHA’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.

2. the licensed HHA 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

3. the licensed HHA continues to submit required documentation and information to the department, including but not limited to cost reports.

B. Upon receiving a completed written request to temporarily inactivate an HHA, the department shall issue a notice of inactivation of its license to the HHA.

C. Upon the agency’s receipt of the department’s approval of request to inactivate the HHA’s license, the HHA shall have 90 days to submit plans for the repairs, renovations, rebuilding, or replacement of the HHA.

D. The licensed HHA shall resume operating as an HHA in the same service area within one year.

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

E. Upon completion of repairs, renovations, rebuilding or replacement of the agency, an HHA which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the HHA shall submit a written license reinstatement request to the agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey; and

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

4. Repealed.

F. Upon receiving a completed written request to reinstate an HHA license, the department may conduct a licensing

survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

G. No CHOW in the HHA shall occur until such HHA has completed repairs, renovations, rebuilding or replacement construction and has resumed operation as an HHA.

H. The provisions of this Subsection shall not apply to an HHA which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the home health agency license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9118. Operation of Branch Offices [Formally §9117]

A. Branch Office Approval. No branch office may be opened without written approval from the department. In order for a branch office to be approved, the parent agency shall have full

licensure for at least one year. Branch office approval shall be renewed at the time of renewal of the parent agency's license if the parent agency meets the requirements for licensure.

B. Identification. The branch shall be held out to the public as a branch or division of the parent agency, so that the public shall be aware of the identity of the agency operating the branch. Reference to the name of the parent agency shall be contained in any written documents, signs, or other promotional materials relating to the branch.

C. Personnel Records. Original personnel files shall not be maintained at the branch office.

D. Survey. A branch office is subject to survey by the department at any time to determine compliance with the minimum standards which apply to HHAs.

E. Operational Requirements. A branch office shall:

1. serve a part of the geographic service area approved for the parent agency;

2. offer all home health services provided by the parent agency;

3. retain all original clinical records for its patients. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state surveyors during any review upon request; and

4. make personnel policies available to all HHA employees, including employees of the branch office

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR:48

§9119. Personnel Policies and Records

A. Personnel Policies. Each HHA shall develop and implement personnel policies. The policies shall be reviewed on an annual basis and shall specify agency requirements regarding the following:

1. – 6. ...

7. continuing education related to health care activities:

a. health professionals shall attend inservice training as required by respective licensing boards.

b. home health aides shall attend inservice training 12 hours per calendar year;

8. – 10. ...

11. payroll;

12. criminal background investigations (history check), if applicable; and

13. a process for checking the direct service worker registry and the Louisiana certified nurse aide registry upon

hiring an employee, and every six months thereafter, to ensure that non-licensed personnel do not have a finding placed against him/her of abuse, neglect, or misappropriation of funds of an individual. If there is such a finding on the DSW and/or CNA registry, the applicant shall not be employed, nor shall a current employee have continued employment with the HHA.

B. Personnel Records. Original personnel files shall be maintained either at the parent agency or integrated with the human resources department of a hospital, agency home office or the parent corporation of the agency. Personnel records shall be made available to surveyors on request. There shall be a personnel record on file for each employee and contract staff member including, but not limited to, the following information:

1. – 8. ...

9. documentation of continuing education;

10. criminal background investigation (history check), if applicable; and

11. registry checks, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001), amended by the

Department of Health, Bureau of Health Services Financing, LR 48:

§9120. Home Health Agency Responsibilities

A. Prior to hiring any non-licensed person, the home health agency HHA shall:

1. ensure that the individual is at least 18 years of age;

2. document that the individual is able to read, write and compare the English language; and

3. access the DSW/CNA registry to determine if there is a finding that a prospective hire, or currently employed or contracted non-licensed person, has been determined to have committed exploitation, extortion, abuse or neglect of an individual being supported, or misappropriated the individual's property or funds.

4. Access to the registry shall be limited to an inquiry for a specific individual.

B. The HHA shall have a written policy/process to check the DSW/CNA registry on the department's designated database at least every six months to determine if any currently employed or contracted non-licensed person has been placed on the registry with a finding that he/she has been determined to have committed abuse or neglect of an individual being supported or

misappropriated the patient’s property or funds or committed exploitation or extortion of a patient.

1. The HHA shall follow the agency’s process in demonstration of compliance with this procedure.

2. If there is such a finding on the registry, the employee shall not have continued employment as a non-licensed person with the HHA.

NOTE: The DSW/CNA registry is maintained on the department’s designated database which may also contain other exclusionary information on a non-licensed person. The HHA’s responsibility to access the database shall also be conducted in accordance with other departmental Rules and regulations, as applicable.

C. Criminal History. In accordance with R.S. 40:1203.1-5 et seq., the HHA shall have a written policy and process to request in writing a security check and the criminal history of an employee, either contracted or directly employed, conducted by the Louisiana State Police or authorized agency, upon offer of employment or contract.

1. The HHA may make an offer of temporary employment to a non-licensed person pending the results of the criminal history and security check on the person. In such instances, the HHA shall provide to the Louisiana State Police, or authorized agency, the name and relevant information relating to the person

within 72 hours after the date the person accepts temporary employment.

2. The security check shall consist of the use of personal identifiers, such as name, social security number, date of birth, and driver's license number, to search the national sex offender public registry. The HHA shall obtain from the Louisiana State Police or the authorized agency the results of the security check to verify if an applicant is listed in the national sex offender public registry.

3. Any home health aide offered temporary employment prior to the receipt of the results of the required criminal history and security check shall be under the direct supervision of a permanent employee or shall be in the presence of a member of the immediate family of the patient or of a caregiver designated by the immediate family of the patient.

a. For purposes of this Paragraph, member of the immediate family means a child, parent, grandparent, sibling, uncle, aunt, nephew, or niece of the patient related by blood, marriage, or adoption.

D. The provisions of this Section shall apply to non-licensed persons who are compensated, either by direct employment or through contract, regardless of the setting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

§9121. Emergency Preparedness

A. The HAA shall have an emergency preparedness plan which conforms to the current Office of Emergency Preparedness model plan and is designed to manage the consequences of natural disasters or other emergencies that disrupt the HHA's ability to provide care and treatment or threaten the lives or safety of its patients. The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from the Louisiana Office of Emergency Preparedness.

B. At a minimum, the agency shall have a written plan that describes:

1. the evacuation procedures for agency patients who require community assistance as well as for those with available caregivers to another location;

2. the delivery of essential care and services to agency patients, whether they are in a shelter or other locations;

3. ...

4. a plan for coordinating transportation services required for evacuating agency patients to another location; and

5. assurance that the agency shall notify the patient’s family or caregiver, if patient is evacuated to another location.

C. The HHA’s plan shall be activated at least annually, either in response to an emergency or in a planned drill. The HHA’s performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if the agency's performance during an actual emergency or a planned drill indicates that it is necessary.

D. Any updates or revisions to the plan shall be submitted to the parish Office of Emergency Preparedness for review. The parish Office of Emergency Preparedness shall review the HHA’s plan by utilizing community wide resources.

E. As a result of an evacuation order issued by the parish Office of Emergency Preparedness (OEP), it may be necessary for an HHA to temporarily relocate outside of its licensed geographic service area. In such a case, the agency may request a waiver to operate outside of its licensed location for a time period not to exceed 90 days in order to provide needed services to its patients and/or other evacuees of the affected areas. The agency shall provide documentation as required by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001), LR 32:846 (May 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9123. Patient Care Standards

A. Admission Criteria. The HHA shall follow written policies in making decisions regarding the acceptance of patients for care. Decisions shall be based upon medical and social information provided by the patient's attending authorized healthcare provider, and the patient and/or the family as well as the agency resources available to meet the needs of potential patients. The HHA shall accept patients for care without regard to age, color, creed, sex, national origin or handicap. Patients shall be admitted to an agency based on the following written criteria:

1. the ability of the agency and its resources to provide services on a timely basis and available within 24 hours unless specified otherwise by authorized healthcare provider’s orders and in accordance with the needs of the patients;

2. the willingness of the patient and caregiver to participate in the POC;

3. – 4. ...

B. Admission Procedure. Patients are to be admitted only upon the order of the patient's authorized healthcare provider. The patient shall have the right to choose an authorized healthcare provider and an HHA without interference. Admission procedures are as follows:

1. an initial visit shall be made by an RN or an appropriate therapist who shall perform the assessment and instruct the patient regarding home care services. This visit shall be made available to an individual in need within 24 hours of referral unless otherwise ordered by an authorized healthcare provider;

2. an initial POC shall be completed by an RN or an appropriate therapist and incorporated into the patient's clinical record within seven days from the start of care; and

3. documentation shall be obtained at admission and retained in the clinical record including:

a. the referral for home care and/or authorized healthcare provider’s order to assess patient;

b. – m. ...

C. Plan of Care. The POC for each patient shall be individualized to address the patient's problems, goals, and required services.

1. The POC, telephone and/or verbal orders shall be signed by the authorized healthcare provider within a timely

manner, not to exceed 60 days; such orders may be accepted by an RN, a qualified therapist or a licensed practical nurse as authorized by state and federal laws and regulations.

a. – b. Repealed.

2. Agency staff shall administer services and treatments only as ordered by the authorized healthcare provider.

3. A POC for continuation of services shall be completed by an RN or an appropriate therapist and incorporated into the patient's clinical record within seven days from the date of the development of the POC.

D. Review of the Plan of Care. The total POC shall be reviewed by the patient's attending authorized healthcare provider in consultation with the agency's professional personnel at such intervals as required by the severity of the patient's illness, but at least once every two months.

E. Drugs and Biologicals. The agency shall institute procedures that protect the patient from medication errors. Agency policy and procedures shall be established to ensure that agency staff has adequate information regarding the drugs and treatments ordered for the patient.

1. Agency staff shall only administer drugs and treatments as ordered by the authorized healthcare provider.

2. Only medications dispensed, compounded or mixed by a licensed pharmacist and properly labeled with the drug name, dosage, frequency of administration and the name of the prescribing authorized healthcare provider shall be administered.

3. The agency shall provide verbal and written instruction to patient and family as indicated.

F. Coordination of Services. Patient care goals and interventions shall be coordinated in conjunction with providers, patients and/or caregivers to ensure appropriate continuity of care from admission through discharge.

1. All agencies shall provide for nursing services at least eight hours a day, five days a week and be available on emergency basis 24 hours a day, seven days a week. Agencies shall maintain an on-call schedule for RNs.

2. The agency shall maintain a system of communication and integration of services, whether provided directly or under arrangement, that ensures identification of patient needs and barriers to care, the ongoing coordination of all disciplines providing care, and contact with the authorized healthcare provider regarding relevant medical issues.

G. Discharge Policy and Procedures

1. The patient may be discharged from an agency when any of the following occur:

a. – e. ...

f. conditions in the home are no longer safe for the patient or agency personnel. The agency shall make every effort to satisfactorily resolve problems before discharging the patient and, if the home is unsafe, make referrals to appropriate protective agencies;

g. the patient's authorized healthcare provider fails to renew orders for the patient;

h. – j. ...

k. 30 days advance written notice has been provided to the patient, or responsible party, when applicable and appropriate; and

l. death of the patient.

2. The agency shall have discharge procedures that include, but are not limited to:

a. notification of the patient's authorized healthcare provider;

b. – c. ...

d. forwarding of the discharge summary to the authorized healthcare provider.

3. The following procedures shall be followed in the event of the death of a patient in the home:

a. ...

b. the HHA parent office shall be notified;

c. the HHA personnel in attendance shall offer whatever assistance they can to the family and others present in the home; and

d. progress notes shall be completed in detail and shall include observations of the patient, any treatment provided, individuals notified, and time of death, if established by the authorized healthcare provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9125. Patient Rights

A. The patient, or representative if appropriate, shall be informed of the patient’s rights in receiving home care services in a language and manner the individual understands. The patient has the right to exercise his/her rights as a patient of the HHA. If the patient has been judged incompetent, the family or guardian may exercise the patient's rights. The agency shall protect and promote the exercise of these rights. The patient has the right to:

1. have his or her property and person treated with respect;

2. be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;

a. – d. Repealed.

3. make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA;

a. Repealed.

4. participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:

a. completion of all assessments;

b. the care to be furnished, based on the comprehensive assessment;

c. establishing and revising the POC;

d. the disciplines that will furnish the care;

e. the frequency of visits;

f. expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;

g. any factors that could impact treatment effectiveness; and

h. any changes in the care to be furnished.

5. receive all services outlined in the POC;

a. – b.i. Repealed.

6. have a confidential clinical record;

7. be advised, orally and in writing, of:

a. the extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA;

b. the charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA;

c. the charges the individual may have to pay before care is initiated; and

d. any changes in the information provided in accordance with §9125.A.7 when they occur. The HHA shall advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit.

8. receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care, or in advance of the HHA reducing or terminating on-going care;

9. be advised of the state toll-free home health telephone hot line, its contact information, its hours of

operation, and that its purpose is to receive complaints or questions about local HHAs;

10. be advised of the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where the patient resides:

a. agency on aging

b. center for independent living;

c. protection and advocacy agency;

d. aging and disability resource center; and

e. quality improvement organization.

11. be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity;

12. be informed of the right to access auxiliary aids and language services and how to access these service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21: 177 (February 1995), LR 27:2251 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9127. Contract Services

A. ...

1. Contract Requirements. Whenever services are provided by an outside agency or individual, there shall be a written contract. The contract shall include each of the following items:

a. – b. ...

c. a statement that services provided to the patient are in accordance with a POC established by the patient's authorized healthcare provider in conjunction with the HHA staff and, when appropriate, others involved in the patient's care;

d. a statement that services are being provided within the scope and limitations set forth in the POC, and may not be altered in type, scope, or duration by the contractor;

e. assurance that the contractor meets the same requirements as those specified for HHA personnel such as staff qualifications, functions, evaluations, orientation and in-service training. The agency shall be responsible for assuring the contractor's compliance with the personnel policies required for an HHA during the contractual period;

f. – h. ...

B. Contract Review. The HHA and contractor shall document review of their contract on an annual basis.

C. Coordination of Contract Services. The HHA shall coordinate services with contract personnel to assure continuity of patient care.

NOTE: Administration and one other service shall be provided directly by the agency at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2251 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9129. Clinical Records

A. Requirements. A clinical record containing past and current findings shall be maintained either electronically or in paper form for every patient who is accepted by the agency for home health service and shall be accessible to authorized agency staff as needed. In addition, the agency shall comply with the following requirements for clinical records.

1. The information contained in the clinical record shall be accurate and immediately available to the patient's authorized healthcare provider and appropriate HHA staff. The record may be maintained electronically.

2. All entries shall be legible, clear, complete, and appropriately authenticated and dated. Authentication shall include signatures or a secured computer entry with the unique identifier of a primary author who has reviewed and approved the entry.

3. The original clinical records of active patients may be kept in the branch office for the convenience of the staff providing services. The records of patients whose services are provided by parent office staff shall be kept in that office.

4. ...

5. A signed consent for treatment form shall be obtained from the patient and/or the patient's family and retained in the record.

6. When applicable, a signed release of information form shall be obtained from the patient and/or the patient's family and a copy shall be retained in the record.

7. Records maintained either in paper or electronically shall be made available to LDH staff upon request.

8. Records shall be retained either electronically or in paper form for a period of not less than six years from the date on which the record was established and, if there is an

audit or litigation that involves the records, the timeframe may be extended.

9. The agency shall have internal policies that provide for the retention of clinical records even if the agency discontinues operation.

10. Repealed.

11. Repealed.

B. Clinical Note. A clinical note shall be legibly written by the person making the visit and incorporated into the clinical record within one week of the visit. A patient care clinical note shall be completed on each visit and shall contain the following, at a minimum:

1. – 5. ...

6. vital signs, according to authorized healthcare provider’s order or accepted standards of practice; and

7. ...

NOTE: The patient or a responsible person shall sign the permanent record of visit that is retained by the agency. However, it is not necessary for the patient or a responsible person to sign on the clinical note.

C. Clinical Record Contents. An active clinical record shall contain all of the following documentation:

1. ...

2. the current POC signed and dated by the authorized healthcare provider.

3. ...

4. the current clinical notes for at least the past 60 days, including a description of measurable outcomes relative to the goals in the POC that have been achieved;

5. – 6. ...

7. attending authorized healthcare provider data, including:

a. – c. ...

8. the diagnoses, including all conditions relevant to the current POC;

9. – 16. ...

17. when applicable, a copy of the transfer form that was forwarded to the appropriate health care facility that shall be assuming responsibility for the patient's care; and

18. the discharge summary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), amended LR 22:1135 (November 1996), LR 27:2252

(December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

§9131. Quality Assessment and Performance Improvement

A. The HHA shall develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-drive quarterly quality assessment and performance improvement (QAPI) program. The HHA's governing body shall ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes and takes actions that address the HHA's performance across the spectrum of care.

B. The HHA shall maintain documentary evidence of quarterly QAPI activities and be able to demonstrate its operation. The evaluation shall consist of an overall policy and administrative review and a quarterly clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. The results of the quarterly QAPI evaluation shall be reported to the governing body which is legally responsible for the operation of the agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116.31 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2253 (December 2001), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
(LAC 50:V.Subpart 5)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.Subpart 5 and repealed the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
August 20, 1983	Change in Limits for Outpatient Hospital Services	Volume 9, Number 8	551
August 20, 1983	Discontinuance of Reimbursement to Emergency Access Hospitals	Volume 9, Number 8	552
December 20, 1985	MAP Outpatient Surgeries	Volume 11, Number 12	1147
November 20, 2000	Outpatient Hospital Services - Medicare Part B Claims	Volume 26, Number 11	2622
July 20, 2003	Outpatient Hospital Laboratory Services	Volume 29, Number 7	1096
December 20, 2003	Hospital Program - Out-of-State Hospitals - Outpatient Services - Reimbursement Reduction	Volume 29, Number 12	2802
December 20, 2004	Hospital Program - Outpatient Surgery Services - HIPAA Implementation	Volume 30, Number 12	2830
February 20, 2007	Hospital Licensing Standards	Volume 33, Number 2	284

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 5. Outpatient Hospital Services

Chapter 53. Outpatient Surgery

Subchapter A. General Provisions

§5301. Payment for Outpatient Surgery Services

A. Payment for outpatient surgery services is a flat rate in accordance with the published fee schedule. The flat rate payment covers all services provided during the outpatient surgical admission. There shall be no cost settlement for outpatient surgery services except for the specific hospital types identified in Subchapter B of this Chapter.

1. Effective for dates of service on or after February 10, 2022, the Medicaid Program shall provide reimbursement for Coronavirus Disease 2019 laboratory testing in addition to the outpatient surgery fee schedule flat fee reimbursement 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, Bureau of Health Services Financing, LR 48:

Subchapter B. Reimbursement Methodology

§5313. Non-Rural, Non-State Hospitals

A. – D. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. – M.1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2534 (December 2017), LR 44:2166 (December 2018), LR 45:1773 (December 2019), LR 46:1685 (December 2020), LR 48:

Chapter 55. Clinic Services

Subchapter A. General Provisions

§5501. Payment for Outpatient Hospital Clinic Services

A. Payment for outpatient hospital clinic services is a flat rate in accordance with the published fee schedule. There

shall be no cost settlement for outpatient clinic services except for the specific hospital types identified in Subchapter B of this Chapter.

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 48:

Subchapter B. Reimbursement Methodology

§5513. Non-Rural, Non-State Hospitals

A. – D. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. – L.1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042

(September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019), LR 48:

Chapter 57. Laboratory Services

Subchapter A. General Provisions

§5701. Payment for Outpatient Hospital Laboratory Services

A. Payment for outpatient hospital laboratory services is a flat rate in accordance with the published fee schedule. There shall be no cost settlement for outpatient laboratory services.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

Subchapter B. Reimbursement Methodology

§5713. Non-Rural, Non-State Hospitals

A. – D. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. – L.2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019), LR 48:

Chapter 59. Rehabilitation Services

Subchapter A. General Provisions

§5901. Payment for Outpatient Hospital Rehabilitation Services

A. Payment for outpatient hospital rehabilitation services is a flat rate in accordance with the published fee schedule. There shall be no cost settlement for outpatient rehabilitation services except for the specific hospital types identified in Subchapter B of this Chapter.

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 48:

Chapter 61. Other Outpatient Hospital Services

Subchapter A. General Provisions

§6101. Payment for Other Outpatient Hospital Services

A. Interim payment for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgery services, rehabilitation services, and outpatient hospital clinic services shall be at a hospital-specific cost to charge ratio. Final payment shall be a percentage of cost amount as detailed for each type of hospital in Subchapter B of this Chapter. The percentage shall be applied to cost for these services as calculated based on the finalized cost report.

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 48:

Subchapter B. Reimbursement Methodology

§6115. Non-Rural, Non-State Hospitals

A. – D. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. ...

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. – L.1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2168 (December 2018), LR 45:1774 (December 2019), LR 48:

Chapter 69. Out-of-State Hospitals

Subchapter A. Reserved

Subchapter B. Reimbursement

§6915. Reimbursement Methodology

A. Reimbursement for all Louisiana Medicaid recipients who receive outpatient services in an out-of-state hospital, including those recipients up to the age of 21, shall be calculated as follows:

1. Outpatient services provided in out-of-state hospitals that are subject to a fee schedule in-state shall be paid at the fee schedule amounts utilized for in-state non-rural, non-state hospitals.

2. Outpatient services provided in out-of-state hospitals that are not subject to a fee schedule in-state shall be paid at the annual average cost to charge ratio calculated from the filed Medicaid cost reports for in-state non-rural, non-state hospitals multiplied by the percent of allowable cost as specified in §6115 that is in effect for the applicable time period for in-state non-rural, non-state hospitals. This ratio shall be applied to the billed charges for covered claims submitted by out-of-state hospitals to determine payment for non-fee schedule services.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

Chapter 71. Medicare Part B Claims for Medicaid Eligible Recipients

Subchapter A. Reserved

Subchapter B. Reimbursement

§7115. Reimbursement Methodology

A. To determine the amount that Medicaid will reimburse on a claim for a Medicaid recipient who is also eligible for Medicare Part B, the Medicare claim payment is compared to the Medicaid rate on file for the revenue or procedure codes on the Medicare Part B claims for outpatient hospital services. If the Medicare payment exceeds the Medicaid rate, the claim is adjudicated as a paid claim with a zero payment. If the Medicaid rate exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment, if any, shall be considered to be payment in full for the service.

B. The recipient does not have any legal liability to make payment for the service.

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 48:

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.

Dr. Courtney N. Phillips

Secretary