RULE

Department of Health and Hospitals
Bureau of Health Services Financing and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Children's Choice Waiver
(LAC 50:XXI.11527)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.11527 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 9. Children's Choice

Chapter 115. Providers

Subchapter B. Provider Requirements

§11527. Direct Service Providers

A. - A.3.d. …

e. All services must be performed and completed during the current approved plan of care year. Services that are not completed by the end of the current approved plan of care

year will be voided and deemed as non-billable. Services cannot carry over into the next plan of care year.

4. - 7. …

8. The agency shall document that its employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404(b). Providers of community supported living arrangement services must:

a. not use individuals who have been convicted of child abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and

8.b. - 12. …

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, Bureau of Health Services Financing, LR 28:1985 (September 2002), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), LR 41:127 (January 2015), repromulgated by the Department of Health

and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:

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

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Provider Fee Increase
(LAC 50:VII.32903)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:VII.32903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH–MEDICAL ASSISTANCE

Part VII. Long Term Care

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32903. Rate Determination

A. - D.4.d.

i. Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to $16.15 per day.

E. - M. ...

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 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Laboratory and Radiology Services
Reimbursement Methodology
Manual Pricing
(LAC 50:XIX.Chapter 43)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XIX.Chapter 43 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIX. Other Services
Subpart 3. Laboratory and X-Ray

Chapter 43. Billing and Reimbursement

Subchapter B. Reimbursement

§4329. Laboratory Services (Physicians and Independent Laboratories)

A. - L.3.a. …

M. Effective for dates of service on or after May 20, 2014, the reimbursement for laboratory services shall be based on usual and customary billed charges or the Medicaid fee on file as of May 19, 2014, whichever is lesser.

1. If laboratory services do not have Medicare

established rates, fees will be based on review of statewide billed charges for that service in comparison with set charges for similar services.

2. If there is no similar service, fees are based upon the consultant physicians' review and recommendations.

3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, 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 28:1025 (May 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3028 (October 2011), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:95 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1284 (May 2013), LR 41:

§4334. Radiology Services

A. - J. ...

K. Effective for dates of service on or after May 20, 2014,

the reimbursement for radiology services shall be based on usual and customary billed charges or the Medicaid fee on file as of May 19, 2014, whichever is lesser.

1. If radiology services do not have Medicare established rates, fees will be based on review of statewide billed charges for that service in comparison with set charges for similar services.

2. If there is no similar service, fees are based upon the consultant physicians' review and recommendations.

3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013), LR 41:

§4335. Portable Radiology Services

A. - H. …

I. Effective for dates of service on or after May 20, 2014, the reimbursement for portable radiology services shall be based on usual and customary billed charges or the Medicaid fee on file as of May 19, 2014, whichever is lesser.

1. If portable radiology services do not have Medicare established rates, fees will be based on review of statewide billed charges for that service in comparison with set charges for similar services.

2. If there is no similar service, fees are based upon the consultant physicians' review and recommendations.

3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

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

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

§4337. Radiation Therapy Centers

A. - H. …

I. Effective for dates of service on or after May 20, 2014, the reimbursement for radiology services provided by radiation therapy centers shall be based on usual and customary billed charges or the Medicaid fee on file as of May 19, 2014, whichever is lesser.

1. If radiology services provided by radiation therapy centers do not have Medicare established rates, fees will be based on

review of statewide billed charges for that service in comparison with set charges for similar services.

2. If there is no similar service, fees are based upon the consultant physicians' review and recommendations.

3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013), LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing and
Office of Aging and Adult Services

Personal Care Services - Long-Term
Freedom of Choice and Service Delivery
(LAC 50:XV.12901 and 12913)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XV.12901 and §12913 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. - F.2.b. …

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

a. the Program of All-Inclusive Care for the

Elderly;

b. Long-term Personal Care Services;

c. the Community Choices Waiver; and

d. the Adult Day Health Care Waiver.

G. The Department of Health and Hospitals may remove an LT-PCS service provider from the LT-PCS provider freedom of choice list and offer freedom of choice to LT-PCS participants when:

1. one or more of the following departmental proceedings are pending against a LT-PCS participant's service provider:

a. revocation of the provider's home and community-based services license;

b. exclusion from the Medicaid Program;

c. termination from the Medicaid Program; or

d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the service provider's assets have been seized by the Louisiana Attorney General's Office.

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 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013), LR 41:

§12913. Service Delivery

A. - B. ...

C. Participants are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the participant.

1. The provisions of §12913.C may be waived with prior written approval by OAAS or its designee.

D. - F. ...

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 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), LR 41:

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

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Professional Services Program
Physicians Services
Reimbursement Methodology
(LAC 50:IX.15113)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:IX.15113 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part IX. Professional Services Program
Subpart 15. Reimbursement

Chapter 151. Reimbursement Methodology

Subchapter B. Physician Services

§15113. Reimbursement

A. - I.3. ...

J. - J.4. Reserved.

K. ...

L. The reimbursement for newly payable services not covered by Medicare, when there is no established rate set by Medicare, shall be based on review of statewide billed charges for that service in comparison with set charges of a similar service.

1. If there is no similar procedure or service, the reimbursement shall be based upon a consultant physicians' review and recommendations.

2. For procedures which do not have established Medicare fees, the Department of Health and Hospitals, or its designee, shall make determinations based upon a review of statewide billed charges for that service in comparison with set charges for similar services.

3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1252 (June 2010), amended LR 36:2282 (October 2010), amended LR 37:904 (March 2011), LR 39:3301 (December 2013), LR 41:

Kathy H. Kliebert

Secretary