

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1285, and 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1645 (August 2007).

§7441. Action against Registration

A. For noncompliance with any of the provisions of this Chapter the board may, in addition to or in lieu of administrative proceedings against a physician's license, suspend, revoke, or cancel a physician's registration to engage in collaborative drug therapy management or impose such terms, conditions or restrictions thereon as the board may deem necessary or appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1285, and 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1646 (August 2007).

§7443. Unauthorized Practice

A. Nothing in this Chapter shall be construed as authorizing a pharmacist to issue prescriptions, exercise independent medical judgment, render diagnoses, provide treatment, assume independent responsibility for patient care, or otherwise engage in the practice of medicine as defined in the Medical Practice Act. Any person who engages in such activities, in the absence of medical licensure issued by the board, shall be engaged in the unauthorized practice of medicine and subject to the penalties prescribed by the Medical Practice Act.

B. Any physician who associates with or assists an unlicensed person engage in the practice of medicine shall be deemed to be in violation of R.S. 37:1285(A)(18), providing cause for the board to suspend, revoke, refuse to issue or impose probationary or other restrictions on any license to practice medicine in Louisiana held or applied for by a physician culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1271, 1285, 1286, 1290, and R.S. 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1646 (August 2007).

Robert L. Marier, M.D.
Executive Director

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RULE

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

**Nursing Facilities—Reimbursement Methodology
Private Room Conversions (LAC 50:VII.1310)**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts §1310 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 Services

Subpart 1. Nursing Facilities

Chapter 13. Reimbursement Methodology

§1310. Additional Payments and Square Footage

Adjustments for Private Room Conversion

A. Effective for dates of service on or after September 1, 2007, Medicaid participating nursing facilities that convert a semi-private room to a Medicaid-occupied private room are eligible to receive an additional \$5 per diem payment. Facilities that participate will have their fair rental value per diem revised based on the change in licensed beds.

B. Qualifying Facilities

1. In order for a nursing facility's beds to qualify for an additional \$5 per diem payment, a revised fair rental value (FRV), a revised property tax pass-through, and revised property insurance pass-through, all of the following conditions must be met.

a. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

b. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the \$5 per diem payment.

c. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

d. The nursing facility must submit the following information to the department within 30 days of the private room conversion:

i. the number of rooms converted from semi-private to private;

ii. the revised bed license;

iii. a resident listing by payer type for the converted private rooms; and

iv. the date of the conversions.

C. The additional \$5 per diem payment determination will be as follows.

1. An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.

2. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in §1310.B.1.

3. A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of this Section have been met.

D. The revised fair rental value per diem will be calculated as follows.

1. After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.

2. After a qualifying private room conversion, the allowable square footage per bed used in §1305.D.3.b. will be determined as follows.

a. No Change in Total Square Footage. The total allowable square footage after a qualifying private room conversion will be equal to the total allowable square

footage immediately prior to the conversion, provided no other facility renovations or alterations changing total square footage occur concurrently or subsequently to the private room conversion.

b. Square Footage Changes to Existing Buildings. If a change in total nursing square footage occurs in a building existing on the effective date of this rule and that change is concurrent or subsequent to a private room conversion, the allowable square footage will be determined in accordance with §1305.D.3.b.i as if the private room conversion did not occur.

c. Square Footage Changes Due to New Buildings. Replacement buildings constructed or first occupied after the effective date of this rule will have their allowable square footage calculated in accordance with §1305.D.3.b.i.

3. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 70 percent of the revised annual bed days available after the change in licensed beds.

4. A revised fair rental value per diem will be calculated under §1305.D.3.b. using the allowable square footage according to §1310.D.2, remaining licensed beds, and the revised minimum occupancy calculation.

5. The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria in paragraph §1310.B.1.

E. Reporting

1. To remain eligible for the conversion payments and the allowable square footage calculations, facilities must report Medicaid-occupied private rooms with every annual cost report.

2. The department may also require an alternate billing procedure for providers to receive the additional \$5 private room rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 33:1646 (August 2007).

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Frederick P. Cerise, M.D., M.P.H.
Secretary

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RULE

**Department of Health and Hospitals
Office of the Secretary**

Office for Citizens with Developmental Disabilities

**Home and Community-Based Services Waivers
New Opportunities Waiver**

**Service Cap Increase and Clarification of Services
(LAC 50:XXI.13701 and Chapters 139-143)**

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental

Disabilities amends LAC 50:XXI.13701 and Chapters 139-143 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 Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services
Waivers**

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. ...

B. All NOW services are accessed through the case management agency of the recipient's choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the individual's case manager.

C. Providers must maintain adequate documentation to support service delivery and compliance with the approved plan of care and will provide said documentation at the request of the department.

D. - F. ...

G. Providers shall follow the regulations and requirements as specified in the NOW provider manual.

H. Home and community-based services shall not be reimbursed while the recipient is a patient in an inpatient facility.

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 Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007).

Chapter 139. Covered Services

§13901. Individualized and Family Support Services

A. Individualized and Family Support (IFS) services are direct support and assistance services provided in the home or the community that allow the recipient to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community or for the relief of the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved CPOC.

1. ...

a. Additional hours of IFS day services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral and specified in the approved CPOC.

2. - 2.e. ...

B. IFS services may be shared by up to three waiver recipients who may or may not live together and who have a common direct service provider agency. Waiver recipients may share IFS services staff when agreed to by the recipients and health and welfare can be assured for each individual. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination.