



Leave of Absence and Bed Hold

This section includes leave of absence and bed hold policies pertaining to facilities.

LEAVE OF ABSENCE

Leave of Absence Qualifications

A leave of absence (LOA) may be granted to a recipient in a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), swing bed facility, Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) in accordance with the recipient's individual plan of care and for the specific reasons outlined below. Leaves of absence may be granted for the following reasons:

- A visit with relatives or friends.
- Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons.

Maximum Time Period

If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:

- Eighteen days per calendar year for non-developmentally disabled recipients. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:
 - The request for additional days of leave shall be in accordance with the individual recipient care plan and appropriate to the physical and mental well-being of the patient.
 - At least five days of LTC inpatient care must be provided between each approved LOA.
 - Seventy-three days per calendar year for developmentally disabled recipients.
 - Thirty days for patients in a certified special treatment program for mentally ill recipients or recipients in a mental health therapy and rehabilitation program approved and certified by a local mental health director.

These limits are in addition to bed hold (BH) days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the recipient's bed (bed hold).

LOA Requirements

The following are requirements specific to LOA:

- Provisions for LOAs are part of the patient care plan for NF-A or NF-B.
- Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H or ICF/DD-N facility.
- Readmission *Treatment Authorization Requests* (TARs) are not necessary for recipients returning from a leave of absence if there is a valid TAR covering the return date.
- Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
- A recipient's record maintained in an NF-A, NF-B, ICF/DD, ICF/DD-H or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
- For all NF-A and NF-B recipients, including the mentally disabled, the provider is paid the appropriate NF-A and NF-B rate(s), minus the raw food cost established by the Department of Health Care Services (DHCS) LOA/BH days. The supplemental payment for special treatment programs for the mentally disordered is included in the LOA/BH reimbursement.
- For all ICF/DD, ICF/DD-H or ICF/DD-N recipients, the provider is paid the appropriate ICF/DD, ICF/DD-H or ICF/DD-N rate(s) minus the raw food cost established by DHCS for LOA or bed hold days.
- Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
- At the time of admission, if a recipient has not been an inpatient in any LTC facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations.

Bed Hold for Hospice Recipients Living in a Nursing Facility

The nursing facility may bill for bed hold when the recipient is on leave of absence. Hospice providers should not bill for facility room and board when the recipient is on leave of absence (for example, visiting relatives).

Recipient Failure to Return from Leave of Absence

If a recipient has used the total amount of leave days for the calendar year, the recipient may still be authorized a leave of absence. However, the facility will not receive reimbursement for those authorized leave days.

**LOA and Bed Hold
General Requirements**

General requirements for LOA and Bed Hold (BH) are as follows:

- The day of departure is counted as one day of LOA/BH, and the day of return is counted as one day of inpatient care.
- A facility will hold the bed vacant during LOA/BH.
- A LOA or BH is ordered by a licensed physician.
- A recipient's return from LOA/BH must not be followed by discharge within 24 hours.
- A LOA/BH must terminate on a recipient's date of death.
- A facility claim must identify the inclusive dates of leave.

ACUTE HOSPITALIZATION

Bed Hold Qualifications

When a recipient residing in a nursing facility is admitted to an acute care hospital, (for example, Nursing Facility Level A [NF-A] or Nursing Facility Level B [NF-B], Intermediate Care Facility for the Developmentally Disabled [ICF/DD], Intermediate Care Facility for the Developmentally Disabled-Habilitative [ICF/DD-H], Intermediate Care Facility for the Developmentally Disabled-Nursing [ICF/DD-N] or swing bed) providers must bill Bed Hold (BH) days.

Reimbursement for BH days is subject to the following:

- The BH is limited to a maximum of seven days per hospitalization.
- The attending physician must order the acute hospitalization.
- The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the Skilled Nursing Facility (SNF) that the recipient requires more than seven days of hospital care.

Note: The facility cannot hold a bed after seven days. Claims submitted for BH for more than seven days will be denied.

Reserved Bed Agreements

A reserved bed agreement is a contract between a hospital and NF- A or NF-B, specifying the number of beds an NF reserves for patients from a hospital and the rate of payment paid to the NF by the hospital for this service.

Billing Limitations

NFs must not bill for recipients in beds or bed hold days already reimbursed through a reserved bed agreement. If an NF bills for recipients in beds or bed hold days already reimbursed through a reserved bed agreement, Medi-Cal will recoup.

Statutory and Regulatory Citations

The statutory and regulatory authorities listed below support these billing limitations:

- (A) *Welfare and Institutions Code* (W&I Code), Section 14019(a) states: “Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payer who provides a contractual or legal entitlement to health care services.”
- (B) *California Code of Regulations* (CCR), Section 51470(d) states: “A provider shall not bill or submit a claim to the department of a fiscal intermediary for Medi-Cal covered benefits provided to a Medi-Cal beneficiary:
 - (1) for which the provider has received and retained payment.”
- (C) CCR, Section 51458.1(a) states: “The Department shall recover overpayment to providers including, but not limited to, payments determined to be:
 - (1) In excess of program payment ceilings or allowable costs...
 - (9) For Medi-Cal covered services already paid for by the beneficiary, but not yet refunded, or for services already reimbursed by the Department or other coverage...
 - (13) In violation of any other Medi-Cal regulation where overpayment has occurred.”
- (D) *Code of Federal Regulations* (CFR), Title 42, Section 447.15 states: “A state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.”
- (E) Provider Reimbursement Manual (HCFA Publication 15-1), Section 2105.3 states: “Providers are permitted to enter into reserved bed agreements, as long as the terms of that agreement do not violate provisions of the statute and regulations which govern provider agreements which
 - (1) Prohibit a provider from charging the beneficiary or other party for covered services...”

Leave of Absence to Acute Hospital, Return to NF-B and Return to Acute Hospital

Figure 1. Leave of Absence (LOA) to an acute hospital, return to NF-B and return to acute hospital. This is a sample only. Please adapt to your billing situation.

In this example, a recipient who is staying at an NF-B goes on LOA to an acute hospital for several days, returns to the NF-B and is once again admitted to the acute hospital where the recipient remains. The recipient status will change based on the recipient's plan of care. The Bed Hold (BH) policy with the appropriate patient status code is used in this example.

For additional information about patient status codes, refer to the *Payment Request for Long Term Care (25-1) Completion* section in this manual.

Initial Billing Period

The initial billing period of the recipient under the NF-B care extends from November 1, 2007, through November 10, 2007. Therefore, on line 1, "110107" and "111007" are entered in the *Date of Service* fields (Boxes 12 and 13), and the recipient's status is noted as "00" (still under care) in the *Patient Status* field (Box 14). Also, since the initial billing period is for nine days at the San Francisco County NF-B per diem rate of \$137.95, the gross amount \$1241.55 is entered in the *Gross Amount* field (Box 17). See the *Rates: Facility Per Diem* section in this manual for reimbursement information.

LOA to Acute Hospital

From November 11, 2007, through November 17, 2007, the recipient is on leave of absence to an acute hospital. The patient's status now changes to "06" (leave of absence to acute hospital), which is entered on line 2 in the *Patient Status* field (Box 33), and the accommodation code has changed from "01" (NF-B regular services) to "02" (NF-B leave days) in the *Accommodation Code* field (Box 34). Because the recipient has taken a LOA and the accommodation code has changed, the NF-B per diem rate is now \$132.88. Therefore, the gross amount \$797.28 (132.88 x 6) is entered in the *Gross Amount* field (Box 36). See the *Accommodation Codes for Long Term Care* section in this manual for code information.

Return to NF-B

On November 18, 2007, the recipient returns to the NF-B and remains at the facility until November 26, 2007. The recipient's status changes back to "00" (still under care) on line 3 in the *Patient Status* field (Box 52), the accommodation code changes back to "01" (NF-B regular services), and the NF-B per diem rate is \$137.95. Therefore, the gross amount, \$1103.60 is entered in the *Gross Amount* field (Box 55).

Return to Acute Hospital

On November 27, 2007, the recipient returns to the acute hospital and stays through November 30, 2007, at which point the recipient is discharged to the hospital. Therefore, patient status changes to "08" (recipient has been discharged to the acute hospital) on line 4 in the *Patient Status* field (Box 71). The accommodation code for this billing period changes back to "02" and the per diem rate is \$132.88. Therefore, the gross amount, \$398.64 is entered in the *Gross Amount* field (Box 74).

See the *Payment Request for Long Term Care (25-1) Completion* section in this manual for more information on completing fields 12, 13, 14, 119 and 127.

DO NOT STAPLE IN BAR AREA

PROVIDER'S NAME, ADDRESS, ZIP CODE

ANYHOME FOR THE AGED
1234 MAIN STREET
ANYTOWN CA

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY

2 Provider Number
0123456789

128 Zip Code
958235555

FASTEN HERE

6

PAYMENT REQUEST FOR LONG TERM CARE
STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE
REGARDING THE COMPLETION OF THIS FORM

PLEASE TYPE ALL REQUIRED INFORMATION

← Typewriter Alignment →

1	DELETE	PATIENT NAME DOE JOHN	MEDI-CAL ID NUMBER 90000000A95001	YR OF BIRTH 30	SEX M	TAR CONTROL NO. 012345678	MEDICAL RECORD NO. 12345	ATTED. M/D PROVIDER NUMBER 1234567890				
	BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM 1110107	THRU 111007	PATIENT STATUS 00	ACCOM CODE 01	PRIM. DX CODE 485	GROSS AMOUNT 1198 51	PATIENT LIABILITY/MEDICARE DEDUCT TYPE 0 00	MEDICARE TYPE 0 00	OTHER COVERAGE 0 00	NET AMOUNT BILLED 1241 55	M.D. CERT. <input type="checkbox"/>
2	DELETE	DOE JOHN	90000000A95001	30	M	012345678	12345	1234567890				
	BILL'G LIMIT EXCEPTIONS	111107	111707	06	02	485	797 28	0 00	0 00	0 00	797 28	<input type="checkbox"/>
3	DELETE	DOE JOHN	90000000A95001	30	M	012345678	12345	1234567890				
	BILL'G LIMIT EXCEPTIONS	111807	112607	00	01	485	1065 94	0 00	0 00	0 00	1103 60	<input type="checkbox"/>
4	DELETE	DOE JOHN	90000000A95001	30	M	012345678	12345	1234567890				
	BILL'G LIMIT EXCEPTIONS	112707	113007	08	02	485	387 94	0 00	0 00	0 00	398 64	<input type="checkbox"/>
5	DELETE											
	BILL'G LIMIT EXCEPTIONS											<input type="checkbox"/>
6	DELETE											
	BILL'G LIMIT EXCEPTIONS											<input type="checkbox"/>
	ATTACH-MENTS	PROV. REF. NO.	DATE BILLED 122607									

PLEASE DO NOT MARK IN SHADED AREAS

F.I. USE ONLY

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

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x *M. Jones*

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

25-10Z 03/07

Figure 1. Leave of Absence to Acute Hospital, Return to NF-B and Return to Acute Hospital.

DEVELOPMENTALLY DISABLED (DD) RECIPIENTS

Summer Camp Leave	If an overnight LOA is for summer camp participation by a Developmentally Disabled (DD) recipient, the recipient's attendance must be prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled.
Bed Hold Reimbursement	Skilled nursing and intermediary care facilities may receive reimbursement for recipients attending summer camp.
Facility qualifications	<p>To qualify for reimbursement, a facility must meet the following criteria:</p> <ul style="list-style-type: none"> • Recipient's attendance at camp is prescribed by a licensed physician and approved by an appropriate regional center for the developmentally disabled. • Recipient is not discharged from the facility while attending camp. • Facility holds a recipient's bed during the period of absence. • Term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year.
Bed Hold Termination	<p>The Bed Hold (BH) will terminate and discharge status will take effect under the following circumstances:</p> <ul style="list-style-type: none"> • If a recipient dies while at camp, the BH terminates on the day of death. (Discharge date is the day of death.) • If a recipient is admitted to an acute care hospital from camp, the BH terminates on the day of departure from camp. • If a recipient leaves camp and does not return to the skilled nursing facility, the BH terminates on the day of departure from camp. <p>Billing procedures for summer camp leave is the same as for any overnight leave of absence. Use the appropriate accommodation codes and status codes on the <i>Payment Request for Long Term Care (25-1)</i> form.</p>