Leave of Absence, Bed Hold, and Room and Board

Page updated: December 2023

‹‹This manual section has been retained to provide reference to LTC-related billing instructions for dates of service prior to February 1, 2024. This manual section is not live and does not reflect current billing policy and should not be referenced when billing for dates of service on or after February 1, 2024. For current billing instructions as of February 1, 2024, refer to the appropriate manual section in the Long Term Care Provider Manual.››

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.

Payment for Room and Board Charges for Hospice Patients

Room and board charges for a hospice patient living in a long term care (LTC) facility are billed billing by the hospice provider. The hospice provider is responsible for establishing an agreement with the LTC facility, by which the hospice provider bills and receives payment for the room and board charges at 95 percent of the LTC rate. The hospice provider is required to pass this payment through to the LTC provider, as noted below in the referenced federal regulations that are binding for Medi-Cal providers.

- Title 42, CFR sections 418.100, 418.108 and 418.112 of the Center for Medicare and Medicaid Services (CMS)
- Medicare Benefits Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance, section 20.3, Election of Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries
- Social Security Act Section 1905 paragraph (o)(3)

Bed Hold for Hospice Recipients Living in a Nursing Facility

The hospice provider is not authorized to bill for room and board for the time the hospice patient is on leave from the facility (for example, visiting relatives) and not receiving hospice services. The LTC facility may bill for bed hold when the recipient is on leave of absence.

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 or 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 depart 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 Acute Hospital

Figure 1. Leave of Absence (LOA) to an acute hospital, return to and return to acute hospital. This is a sample only. Please Return to NF-B and 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 October 1, 2015, through October 10, 2015. Therefore, on line 1, “100115” and “101015” 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 October 11, 2015, through October 17, 2015, 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

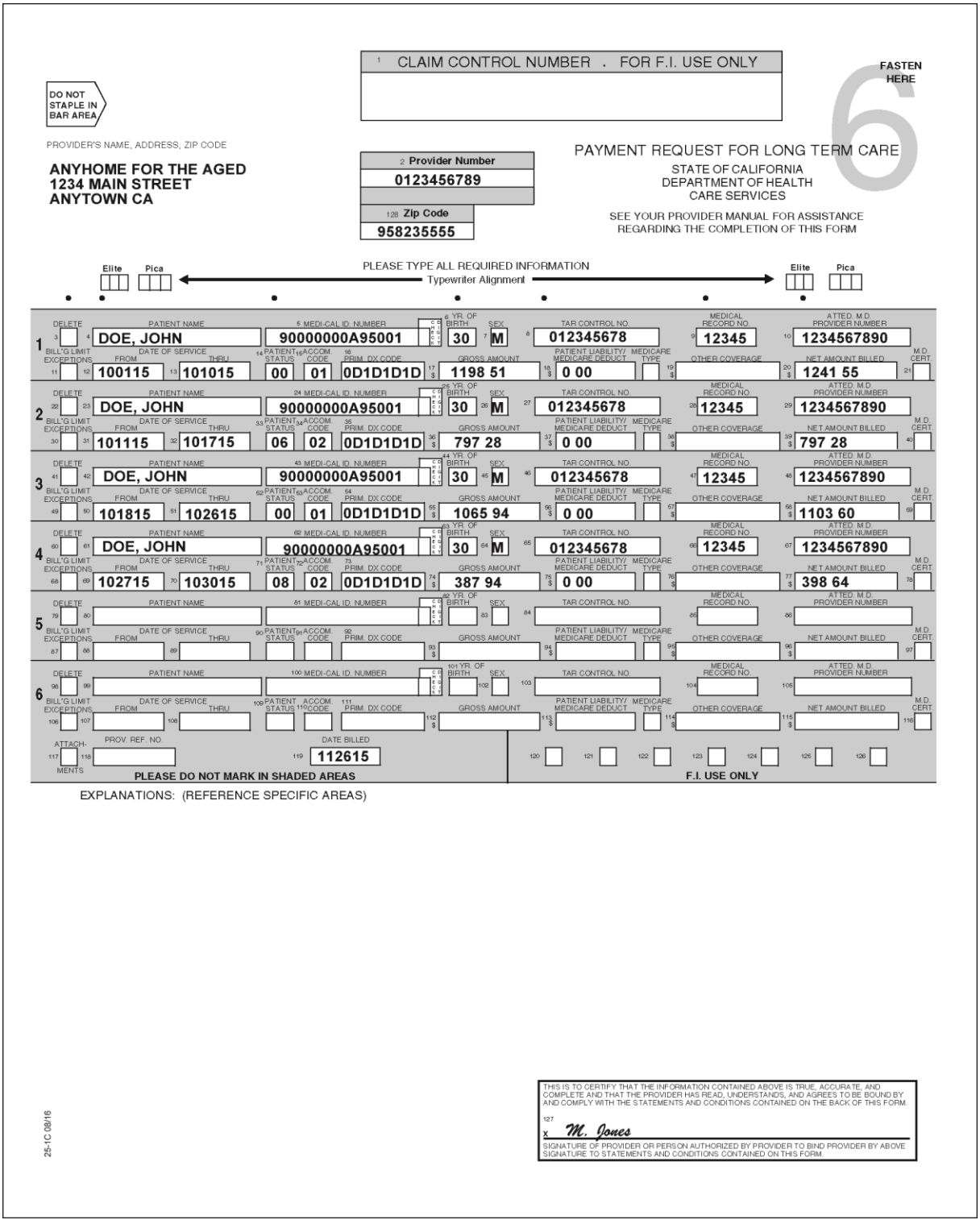
On October 18, 2015, the recipient returns to the NF-B and remains at the facility until October 26, 2015. The recipient’s status changes back to “00” (still under care) on line 3 in the *Patient Status* field (Box 52), the accommodation code changes back to “01” (NF-B regular services), and the NF-B 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 October 27, 2015, the recipient returns to the acute hospital and stays through October 30, 2015, 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.

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



DO NOT STAPLE IN BAR AREA

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

FASTEN HERE

6

PROVIDER'S NAME, ADDRESS, ZIP CODE

ANYHOME FOR THE AGED
1234 MAIN STREET
ANYTOWN CA

2 Provider Number: 0123456789

128 Zip Code: 958235555

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

Elite Pica — PLEASE TYPE ALL REQUIRED INFORMATION — Typewriter Alignment — Elite Pica

	PATIENT NAME	MEDI-CAL ID. NUMBER	BIRTH YR. OF	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER
1	DOE, JOHN	90000000A95001	30	M	012345678	12345	1234567890
2	DOE, JOHN	90000000A95001	30	M	012345678	12345	1234567890
3	DOE, JOHN	90000000A95001	30	M	012345678	12345	1234567890
4	DOE, JOHN	90000000A95001	30	M	012345678	12345	1234567890
5							
6							

	BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM	DATE OF SERVICE THRU	PATIENT STATUS	ACCOM. CODE	PRIM. DX CODE	GROSS AMOUNT	PATIENT LIABILITY/ MEDICARE DEDUCT	MEDICARE TYPE	OTHER COVERAGE	NET AMOUNT BILLED	M.D. CERT.
1		100115	101015	00	01	0D1D1D1D	1198 51	0 00			1241 55	
2		101115	101715	06	02	0D1D1D1D	797 28	0 00			797 28	
3		101815	102615	00	01	0D1D1D1D	1065 94	0 00			1103 60	
4		102715	103015	08	02	0D1D1D1D	387 94	0 00			398 64	
5												
6												

ATTACH-MENTS — PROV. REF. NO. — DATE BILLED: 112615

PLEASE DO NOT MARK IN SHADED AREAS

120 121 122 123 124 125 126

F.I. USE ONLY

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

25-1C 08/16

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.

127 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.

Developmentally Disabled (DD) Recipients

Leave of Absence

Developmentally disabled (DD) recipients can receive a leave of absence (LOA) for relatives/friend visits or summer camp for up to 73 days per calendar year, per CCR, Title 22, Section 51535. If an overnight LOA is for summer camp participation by a DD recipient, the recipient's attendance must be prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled.

Leave of Absence Reimbursement

Skilled nursing and intermediary care facilities will receive reimbursement for DD recipients attending relatives/friend visits or summer camp for up to 73 days per calendar year if the following qualifications are met.

Facility Qualifications

To qualify for reimbursement, a facility must meet the following criteria:

- 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.

Facility Rates

ICF/DDs are allowed to bill to a maximum of 73 days for an approved LOA, per CCR, Title 22, Section 51535. Per CCR, Title 22, Section 51535.1, ICF/DDs are allowed to bill a maximum of seven days for bed hold for acute hospitalization. The LOA and bed hold are paid the same rate. If a facility bills for LOA or bed hold, the facility's base per diem rate is reduced by the bed hold/LOA rate for the respective rate year. The annual bed hold/LOA rate is updated every year and included in the *Rates: Facility Per Diem* section of the Part 2 *Long Term Care* provider manual. These rates are referenced in both CCR sections and require physician approval.

Billing

When the recipient attends camp, this is considered LOA; the facility would bill the LOA accommodation codes for a maximum of 73 days.

Use appropriate accommodation codes and status codes on the *Payment Request for Long Term Care (25-1)* form (accommodation codes for LOA and bed hold are the same).

Example: Assuming the facility bills the full 73 days for LOA, the facility's total annual reimbursement is reduced by $578.16 (73 days x $7.92).

Additional information on bed hold and LOA rates can be found at *www.dhcs.ca.gov/services/medical/Pages/LTCRU.ICF_DD.aspx.*

Leave of Absence Termination

The LOA will terminate and the discharge status will take effect under the following circumstances:

- If the recipient dies while at camp, the LOA terminates on the day of death (discharge date is the day of the death).
- If a recipient is admitted to an acute care hospital from camp, the LOA terminates on the day of departure from camp.
- If a recipient leaves camp and does not return to the skilled nursing facility, the LOA terminates on the day of departure.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.