

Chapter 27

Long-Term Care (LTC)

Long-term care (LTC) facilities provide medical and supportive services for residents who meet both of the following criteria:

1. Have lost some capacity for self-care due to chronic illness or condition
2. Are expected to need care for a temporary or prolonged period of time

Questions about LTC facilities, policy, and services can be directed to the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free).

Definitions

Certified Bed: A bed certified under Title XIX of the Social Security Act.

Certified Nursing Facility (NF): A facility or part of a facility that is licensed to provide nursing care for people who are unable to care for themselves properly.

Discharge: Termination of placement in the NF that is documented in the discharge summary and signed by the physician.

Facility with Distinct Part Certification: Sections of the facility certified as psychiatric, NF, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) must admit and care for those MA recipients certified as requiring the same level of care as the bed certification.

LTC Facility: A residential facility certified by the Minnesota Department of Health (MDH) as a Skilled Nursing Facility (SNF) or as an intermediate care facility, including an ICF/DD.

Leave Day: An overnight absence of more than 23 hours. After the first 23 hours, additional leave days are accumulated each time the clock passes midnight. Absence must be for hospital or therapeutic cause.

Reserved Bed: The same bed that a member occupied before leaving the facility for hospital leave or therapeutic leave, or an appropriately certified bed if the member's physical condition upon returning to the facility prohibits access to the bed he/she occupied before the leave. Commonly referred to as "bed hold."

Short-Term Stay: Nursing facility (NF) admission expected to be less than 14 days.

Swing Bed: A hospital bed that has been granted a license under [MS 144.562](#) and which has been certified to participate in the Federal Medicare program under US code title 42, section 1395. Refer to the *Swing Bed* section of this chapter.

Transfer: Temporary disposition of a member, for whom a bed is being held, to an inpatient hospital.

Eligible Providers

Psychiatric hospitals, SNFs, NFs, boarding care homes (BCHs), and ICF/DDs certified by MDH are eligible to provide LTC services. Swing Bed hospital provider eligibility information is specified in the *Swing Bed* section of this chapter.

Facilities with distinct part certification must admit and care only for those PrimeWest Health members certified as requiring the same level of care as the bed certification.

Exemption: An SNF that is operated, listed, and certified as a Christian Science sanatorium by the First Church of Christ, Scientist of Boston, Massachusetts, is not subject to the Federal regulations for utilization control in order to receive PrimeWest Health payments for the cost of member care.

Eligible Members

LTC facilities provide services to elderly people, people with physical disabilities, and people with developmental disabilities and related conditions.

PrimeWest Health Minnesota Senior Care Plus (MSC+), Special Needs BasicCare (SNBC)*, Prime Health Complete (HMO SNP)** , and PrimeWest Senior Health Complete (HMO SNP)*** eligible members must reside in a certified bed that matches his/her certified level of care.

PrimeWest Health will cover the cost of care for a member who resides in a certified NF, certified BCH, or licensed ICF/DD if all of the following requirements are met:

Certified NF and Certified BCF:

1. The care is ordered by a physician
2. The care is provided in compliance with MDH
3. The care provided in an NF or BCH is required because of physical or mental limitations determined through the Pre-Admission Screening (PAS) process or Long-Term Care Consultation (LTCC) process completed by the county prior to admission to the facility, with certain exceptions defined below.

Swing Bed Hospital:

1. Specifications are in the *Swing Bed* section of this chapter

Utilization Control

Physician Certification

A physician must certify the need for a certified NF, certified BCH, or ICF/DD. A [DHS-1503](#) form must be completed in all of the following instances:

1. Upon initial admission or upon readmission following discharge
2. When a member transfers from one LTC facility to another
3. When a member transfers within a facility from an NF1 (SNF/NF) to an NF2 (Certified BCH) level of care
4. When a member returns from an unauthorized leave exceeding 24 hours
5. When a member returns from hospitalization, if his/her level of care changes

Telephone orders cannot be used for physician certification purposes. Written orders signed and dated by a physician are permissible for this purpose, or a physician may sign and date the [DHS-1503](#) form.

The [DHS-1503](#) form must be completed by the following:

1. **Member:** Within 30 days prior to the admission date, or on the date of admission. Payment will begin on the date the physician signs and dates orders for admission or the [DHS-1503](#), or the actual admission date, whichever is later.
2. **Applicant:** Within two weeks from notification by the county that an MA application was taken. Payment may begin up to three months prior to the month the MA application was taken, based on the local agency's eligibility determination.

*This is PrimeWest Health's Special Needs BasicCare (SNBC) program for members who only have Medicaid coverage through PrimeWest Health

**This is PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have Medicaid and Medicare coverage through PrimeWest Health

***This is PrimeWest Health's Minnesota Senior Health Options (MSHO) program for members who have Medicaid and Medicare coverage through PrimeWest Health

Physician Visits for NF and Boarding Care Recipients

Under State rule, a certified NF or boarding care resident must be examined by a physician within five days prior to or 72 hours after admission. After the admitting examination, the resident must be seen at least every 30 days for the first 90 days after admission and at least every 60 days thereafter.

When a recipient on a 60-day schedule of visits is transferred to a hospital and returns to the same NF, it is not necessary to begin a new 30-day schedule of visits for 90 days. The next required routine physician visit would occur 60 days after the recipient returns from the hospital.

At the discretion of the physician, and in accordance with facility policy, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, certified nurse practitioner, or clinical nurse specialist. The physician assistant, certified nurse practitioner or clinical nurse specialist must not be an employee of the NF. Refer to [Physician & Professional Services, Chapter 6](#), for supervision requirements for physician extenders.

Residents who would otherwise be on a 60-day visit schedule, but refuse to see their physician this often, may waive this requirement. Under State law, physicians must see nursing home residents at least every six months and boarding care home residents at least once per year. Each refusal must be documented in the member's medical record and signed by the resident and the physician.

Discharge and Transfer

When a resident is *discharged*, he/she is terminated from a residential treatment period of care through the formal release or death of the resident. The record must contain a discharge summary signed by a physician, and the facility must notify the county. Payment is not made for reserving a bed after discharge. If the resident returns to the facility, all admission record requirements must be completed.

When a resident is *transferred*, he/she is temporarily placed into an inpatient hospital (not including regional treatment centers or other LTC facilities) and the facility holds the bed for the resident. The medical record must indicate the resident was absent from the facility and, upon return, must be updated with any changes. A transfer does not prohibit a facility from thinning the medical record.

In addition, any transfer, discharge or relocation of residents must comply with all applicable Federal or State laws, including the state Resident Relocation law, found in [M.S. 144A.161](#).

Resident Classification

The new Minnesota case-mix system uses an existing Federally mandated assessment instrument for all nursing facility residents.

Facilities must conduct and electronically submit a case-mix assessment for all residents to MDH.

The assessments used to determine a case-mix classification for reimbursement include the following:

1. A new admission assessment, to be completed by the 14th day following admission
2. An annual assessment, to be completed within 365 days of the last comprehensive assessment
3. A significant change assessment, to be completed within 14 days of the identification of a significant change

A second quarterly assessment, following either a new admission, annual or significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Minnesota law requires the same assessment schedule as is required by the Omnibus Budget Reconciliation Act, 1987 (OBRA) regulations for nursing homes.

Penalty for Late or Non-Submission of Resident Assessment

A facility that fails to complete or submit an assessment for a case-mix classification within seven days of the time required is subject to a reduced rate for that resident. The reduced rate will be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, or on the day that the assessment was due, for all other assessments. The reduced rate continues in effect until the first day of the month following the date of submission of the resident's assessment.

Request for Reconsideration of Resident Classification

The resident, resident's representative, or the NF or BCH may request that MDH reconsider the assigned reimbursement classification. Residents or their representatives have the right to review the MDS and other documentation in the medical record. Facility staff should help explain the assessment process and discuss any MDS items in question. If the resident, resident's representative, or facility staff wish to pursue reconsideration, the request must be submitted in writing to MDH within 30 days of the day the resident or the resident's representative receives the resident classification notice.

For additional information about Minnesota case-mix or to request a reconsideration, contact:

Minnesota Department of Human Services
Case Mix Review Section
P.O. Box 64938
Saint Paul, MN 55164-0938
1-651-201-4301

Nursing Assistant Registry

Nursing Assistant Training and Competency Evaluation

An LTC facility may employ an individual working in the facility as a nursing assistant for more than four months, if the individual:

1. Is a permanent employee, competent to provide nursing and nursing related services; and
2. Has successfully completed an approved training and competency evaluation program **or** a competency evaluation program approved by the state; or
3. Has been deemed or determined competent as provided by MDH.

An LTC facility may employ an individual working in the facility as a nursing assistant for less than four months, if the individual meets one of the following:

1. Is a permanent employee enrolled in an approved training and competency evaluation program
2. Has demonstrated competence through satisfactory participation in a state approved training and competency evaluation program or competency evaluation
3. Has been deemed or determined competent as provided by the MDH.

An LTC facility may employ a non-permanent (temporary or contract) employee working in the facility as a nursing assistant, if the individual:

1. Is competent to provide nursing and nursing-related services; and
2. Has successfully completed a training and competency evaluation program or a competency evaluation program approved by the State.

Nursing facilities may employ an individual to work as a nursing assistant if the individual meets any of the requirements outlined above, but the facility must also seek and obtain a copy of the Nursing Assistant Registry verification for the permanent employment file. In the case of non-permanent (temporary or contract) staff, the nursing facility remains the responsible party to ensure that staff employed in their facility meet all requirements.

Information in Registry

The Nursing Assistant Registry includes substantiated findings of resident abuse, neglect, or misappropriation of resident property involving an individual listed in the Registry. It may also include a brief statement by the individual disputing the findings.

Contacting the Registry

When the Nursing Assistant Registry is contacted by telephone, the LTC facility will receive immediate verbal verification of the individual's status on the Registry. If the nursing assistant is active on the registry, the facility can request an inquiry letter be mailed or faxed verifying the nursing assistant's status. The facility will be instructed to speak to a registry representative if the nursing assistant is inactive, not on the registry, or has abuse allegations or findings on record.

Contact the Registry at:

Minnesota Department of Health
Nursing Assistant Registry
85 East 7th Place, Ste 300
P.O. Box 64501
Saint Paul, MN 55164-0501
1-651-215-8705 or 1-800-397-6124 (toll free)
FPC-NAR@health.state.mn.us

Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact:

Long Term Care Policy Center
1-651-431-2282
DHS.LTCpolicycenter@state.mn.us

Pre-Admission Screening (PAS) Under State and Federal Statutes

Minnesota Statutes and Federal law require that all applicants to certified NFs, hospital Swing Beds, and certified boarding care facilities be screened by the county prior to admission.

The purpose of the PAS program is to prevent or delay certified NF placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs. Another goal of the program is to contain costs associated with unnecessary certified NF admissions. The purpose of the consultation (screening) activity is to determine the need for NF level of care and to complete activities required under Federal law related to mental illness and mental retardation.

Preadmission Screening for Mental Illness or Mental Retardation

All applicants to certified nursing and boarding care facilities, as well as hospital Swing Beds must be screened **prior to admission**, regardless of income, assets, or funding sources and except as outlined below. A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a

PAS before admission, regardless of the exemptions related to level of care determinations outlined below, to identify the need for further evaluation and/or specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The local agency will use qualified professionals and forms and criteria developed by the commissioner to identify people who require referral for further evaluation and determination of the need for specialized services.

The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a NF if the individual does not meet the NF level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508.

Exemptions: Exemptions from the Federal requirements for screening people for mental illness or mental disability (and subsequent referrals for more completed evaluation as needed) are limited to the following:

1. A person who, having entered an acute care facility from a certified NF, is returning to a certified NF
2. A person transferring from one certified NF in Minnesota to another certified NF in Minnesota
3. Certain hospital discharges when all of the following are met:
 - a. The person is entering a certified NF directly from an acute care hospital after receiving acute inpatient care at the hospital
 - b. The person requires NF services for the same condition for which he/she received care in the hospital
 - c. The attending physician has certified, before admission, that the individual is likely to receive less than 30 days of NF services.

ALL of these conditions must be met in order for an admission to be considered exempt from LTCC.

Preadmission Screening (PAS) for NF Level of Care Determination

The determination of the need for NF level of care shall be made according to criteria developed by the commissioner. In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Exemptions: People who are exempt from PAS for purposes of level of care determination include the following:

1. People exempt under the Federal requirements related to screening for mental illness or mental disability as outlined above
2. An individual who has a contractual right to have NF care paid for indefinitely by the Veteran's Administration
3. An individual who is enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project [under MS 256B.69](#), subd. 8, at the time of application to an NF

An individual admitted to a certified NF for a short-term stay that, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for NF admission within the previous six months. This exemption applies only if the screener determines at the time of the initial screening of the six-month period that it is appropriate to use the NF for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. Payment limitations listed below will apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

Individuals Under 21 Years of Age

Exemptions outlined above DO NOT apply to people under age 21. Face-to-face assessment must occur before admission to an NF for all individuals under age 21, regardless of projected length of stay or admission source. At the face-to-face assessment, all community alternatives must be explored and presented to the person, his/her family, and/or the person's representative.

If an NF admission cannot be prevented, the admission must be approved by the PrimeWest Health Care Coordinator or Utilization Management by calling **1-888-588-4420** (toll free).

Preadmission Screening (PAS) and Medical Assistance Reimbursement

Medical Assistance reimbursement for NFs shall be authorized for a PrimeWest Health member only if a PAS has been conducted prior to admission or the local county agency has authorized an exemption. PrimeWest Health reimbursement for NFs shall not be provided for any member whom the local screener has determined does not meet the level of care criteria for NF placement or, if indicated, has not had an evaluation completed unless an admission for a member with mental illness is approved by the local mental health authority or an admission for a member with mental disability or related condition is approved by the State mental disability authority.

The NF shall not bill a person who is not a PrimeWest Health member for resident days that preceded the date of completion of screening activities as required under State and Federal law. The NF must include an un-reimbursed resident day in the NF resident day totals reported to the Minnesota Department of Human Services (DHS).

See [MS 256B.0911](#) and MN Rules [9505.2450](#) for authority for these payment limitations.

Emergency Admissions

People admitted to the Medicaid-certified NF from the community on an emergency basis as described below, or from an acute care facility on a non-working day must be screened the first working day after admission.

Emergency admission to an NF prior to screening is permitted when a person is admitted from the community to a certified nursing or certified boarding care facility during county non-working hours and all of the following apply:

1. The physician has determined that delaying admission until the preadmission screening is completed would adversely affect the person's health and safety
2. There is a recent precipitating event that no longer enables the person to live safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver is unable to continue to provide care
3. The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended

The county screener must be contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to an NF is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation (i.e., stabilization of medications), or care in an emergency room without hospital admission, or following hospital 24-hour bed care.

PAS Summary

The table below summarizes timelines and other requirements for the LTCC as well as some follow-up activity performed by county LTCC staff.

TIMELINES FOR PAS & ASSESSMENTS FOR NF ADMISSIONS	Preadmission Screening	
	Under 65	Over 65
Hospital Discharge: NF admission meets criteria for a 30-day	No PAS required	No PAS required
Inter-facility transfer (NF-NF or NF- Hosp-NF)	No PAS required	No PAS required
Initial admission under a qualifying 30-day exemption but stay exceeds 30 days	By 40 th day of admission: Face-to-face LTCC visit, OBRA Level 1, any needed OBRA Level 2	By 40 th day of admission: telephone screening or face-to-face; OBRA Level 1 and any needed OBRA Level 2
Hospital discharge to NF: Stay projected to be 30 days or longer, or admission doesn't meet other 30-day delay criteria	Before admission: may be telephone or face-to-face. If telephone: LTCC visit must occur within 20 working days of admission.	Before admission: telephone or face-to-face
Admission from a hospital to NF on non-working county day	Next working day after admission LTCC visit within 20 working days of admission if telephone screen	Next working day after admission
Initial screening after emergency NF admission	Next working day after admission LTCC visit within 20 working days of admission if telephone screen	Next working day after admission
Age 20 and under	Face-to-face LTCC & DHS approval required for any admission to NF	--
Required face-to-face assessment for people age 21 – 64 admitted to NF if admitted by telephone screening	Within 20 working days of admission	--

County Responsibility

1. Under certain circumstances, counties have the option to complete a PAS face-to-face or by telephone. PAS must be completed by a public health nurse and/or social worker.
2. The LTC facility must notify all applicants who request admission, and their families, that a PAS is required before admission. The LTC facility must also notify the county PAS screener of all new applicants.
3. Under most circumstances, the “county of location” is responsible for PAS for members requesting admission to a certified NF or certified BCF.
4. If the person leaves a correctional facility (on medical release) to enter an NF, the person must be screened by the county in which the prison is located.
5. If the person is being discharged from the hospital to the NF, contact the county in which the hospital is located.

Nursing Facility and Boarding Care Home Responsibility

NFs' and certified BCFs' responsibilities under the PAS program include the following:

1. Determining if applicant has been screened
2. Informing applicants of PAS program requirements and background
3. Obtaining consent for PAS and notifying the county
4. Providing the screener with pertinent information obtained from the applicant or family

For further details on PAS, contact the PAS (screener) in your county or a Senior Care Coordinator at PrimeWest Health at **1-888-588-4420** (toll free).

The LTC facility should retain the following documents:

1. LTCC notice to resident that he/she has been screened
2. Statement of applicant's choice for placement
3. A copy of the Level I form signed by the screener

Medicare Revenue Enhancement Program (MREP) Process for Nursing Facilities

Federal laws require State Medicaid agencies to be payer of last resort for their Medical Assistance (MA) recipients. Minnesota Health Care Programs (MHCP) developed the Medicare Revenue Enhancement Program (MREP) to do the following:

1. Help NFs and recipients to ensure Medicare coverage is properly used to its maximum
2. Recover Medicaid dollars when Medicare benefits should pay or when Medicare benefits were Appealed and adjusted

MREP's focus is to make sure Medicare and other health care payers are billed first to pay for LTC services. MREP helps identify services covered by Medicare and other payers, requests demand bills, and Appeals coverage decisions.

MREP is responsible to review cases and decide whether to Appeal Medicare's denial on behalf of dual eligible recipients (Medicare and MA). This involves collecting sufficient medical information to assess the merit of requesting a demand bill (DB) or Medicare redetermination and repeating the process at the hearing levels of the Appeals process for denials and redeterminations.

The process requires participation from the nursing home providers. NFs forward medical records to MREP for review of payer source.

The NF follows the following screening process for dual eligible resident recipients:

1. The NF determines Medicare coverage on admission and for a continued stay
2. The NF issues a denial to a recipient when Part A or skilled services are no longer being provided
3. The NF submits the required information to MREP within four weeks of the date of the issued denial

The review process includes:

1. MREP reviews medical records received from the NF for potential Part A/skilled services coverage
2. If MREP determines that Part A/skilled services were provided, MREP will request that the NF submit a demand bill (DB) with the required paperwork in the next billing cycle to the fiscal intermediary (FI). The NF may reverse the original decision and submit a covered claim in place of the demand bill.
3. The NF notifies MREP of the DB outcome
4. If the FI reverses the decision, the NF submits a corrected claim to Medicare for the covered days
5. When the NF receives the Medicare adjustment, it does one of the following:
 - a. Submits a corrected claim and notifies MREP (claim less than a year old)

- b. Faxes a copy of the Medicare remittance advice to MREP (claim is over a year old)
6. If the FI denies Part A coverage, MREP may consider further Appeals based on cost effectiveness of the case
7. If it is a Medicare Advantage program, MREP will collect the necessary documentation, complete a summary of the case, and submit to the appropriate organization for a redetermination. When a redetermination has been reached, MREP will communicate with the NF business office and request a rebilling be completed. When an adjustment has been completed by the NF a copy of the remittance advice will be forwarded to MREP
8. If PrimeWest Health denies Part A coverage, MREP may consider further Appeals based on cost effectiveness of the case

The PrimeWest Health Appeals process does not require a demand bill be sent. Once services are denied by PrimeWest Health, a request for a review of the denied services goes directly to the reconsideration level of Appeal. The request for reconsideration must be made within 60 days from the date that PrimeWest Health made its determination not to cover the stay. It is very important to send the denial referral as soon as the provider knows the SNF has denied the stay or part of the stay.

Covered Services

PrimeWest Health covers room and board care for a PrimeWest Health member in a certified NF or certified BCF. The care and monthly room and board services (per diem) cannot be billed until the beginning of the following month (e.g., January services cannot be billed until February 1).

Items/services usually included in the per diem (not an all-inclusive list):

1. Nursing services
2. Laundry and linen services
3. Dietary services
4. Personal hygiene items necessary for daily personal care (e.g., soap, shampoo, toothpaste, toothbrush, shaving cream, etc.)
5. Over-the-counter drugs or supplies used on an occasional, as needed basis (e.g., aspirin, acetaminophen, antacids, cough syrups, etc.)

180-Day Benefit

PrimeWest Health is responsible for a total of 180 days of nursing home room and board. After the initial 180 days, billing for nursing home care should be submitted to DHS.

If a PrimeWest Health member is residing in a nursing home at the time he/she enrolls in PrimeWest Senior Health Complete, he/she is **not** entitled to the 180-day benefit. **Continue to submit claims for room and board to DHS.**

If a PrimeWest Health member is in the middle of his/her 180-day benefit and enrolls in PrimeWest Senior Health Complete, this benefit ends. DHS is responsible for the member's nursing care.

Respite days **do not** count toward the benefit.

180-Day Separation Period

The member must reside in the community for 180 days after discharge from the SNF in order for the member to be eligible for a new 180-day benefit.

After the member is in the community for 180 days, PrimeWest Health would be responsible for a new, distinct 180-day SNF benefit period for a member who is still community based.

If the member becomes institutionalized prior to the end of the separation period, no new SNF benefit period applies.

100 Medicare Days

PrimeWest Health PrimeWest Senior Health Complete and Prime Health Complete members are entitled to up to 100 days of Medicare coverage if the Medicare qualifications have been met.

PrimeWest Health waives the 3-day qualifying hospital stay for members in the PrimeWest Senior Health Complete/Prime Health Complete program.

The NF should notify PrimeWest Health when the resident enters a Medicare skilled level of care using the [Skilled Nursing Facility Notification Form](#).

Once the 100 days of Medicare coverage are used, the person is **not entitled** to another 100 days, unless there has been a 60-day break from the Medicare skilled level of care.

Claims for the Medicare days for PrimeWest Senior Health Complete and Prime Health Complete enrollees are sent to PrimeWest Health.

A member is entitled to the 100 Medicare days no matter how long he/she has been a resident at the NF, as long as he/she meets the requirements of a skilled level of care.

PrimeWest Health follows Medicare skilled coverage criteria.

PrimeWest Health will issue Medicare denials to the SNF. Assure Medicare denials are issued in a timely manner.

[Skilled Nursing Facility Prime Health Complete/PrimeWest Senior Health Complete Notification Form](#)

This form is used for Prime Health Complete and PrimeWest Senior Health Complete members. This form should be used to notify PrimeWest Health of Medicare days used and notification of the 100- and 180-day benefit. This form must be faxed to PrimeWest Health. **The reason for the skilled coverage should be included in the note section.**

Items/services not included in the per diem (not an all-inclusive list):

PrimeWest Health covers the majority of costs incurred while in an NF. However, a resident may be responsible for some non-covered MA services, such as the following:

1. Special services
2. Other services not covered by MA
3. Spenddown amounts

Additional Charges for Special Services

State law allows a facility to charge residents for special services that are not included in the per diem. Special services must be available to all residents in all areas of the facility and charged separately at the same rate for the same services. In order to qualify as a special service, the following conditions must be satisfied for MA and private-pay residents:

1. The facility must provide a detailed explanation of what is included in the case-mix rate
2. The facility must provide a detailed explanation of the special service and the additional charge
3. The cost of the special service must not have been included in the facility's historical cost in the cost report

for the prior reporting year

4. The service cannot be a licensure or certification requirement
5. Each resident or potential admission must be free to choose whether or not he/she desires to purchase the special service from the facility
6. The facility must allocate and report the cost and charges associated with the provision of special services under unallowable costs in the facility's annual cost report (for those required to file)

Questions regarding nursing facility services may be directed to the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free).

Rehabilitative Services

LTC facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service vendor (rehab agency). Services must be provided on the premises.

The billing party may only bill physical therapy (PT), occupational therapy (OT), and speech- language pathology (SLP) if it is not a part of the facility's per diem. PrimeWest Health will not make separate reimbursement for therapy services for residents of an LTC facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services. Refer to [Rehabilitative Services](#), Chapter 17, for covered services.

Note: The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided. Also, if PrimeWest Senior Health Complete/Prime Health Complete requires the LTC facility to do the billing for PrimeWest Senior Health Complete/Prime Health Complete covered rehabilitative services for dually eligible members, you must follow PrimeWest Senior Health Complete/Prime Health Complete's requirements until PrimeWest Senior Health Complete/Prime Health Complete benefits are exhausted.

Leave Days (SNF/NF/BCH)

Leave days are eligible for MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete payment. A leave day must be for hospital leave or therapeutic leave of a member who has not been discharged from an LTC facility. A reserved bed must be held for a member on hospital leave or therapeutic leave. Payment for leave days in an SNF or NF is limited to 30 percent of the applicable payment rate.

To be eligible for MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete payment, the following criteria must apply:

Hospital leaves:

1. The member must have been transferred from an LTC facility to the hospital
2. The member's record must document the date the member was transferred to the hospital and the date the member returned to the LTC facility
3. The hospital leave days must be reported on the claim submitted by the LTC facility with the appropriate hospital leave revenue code

Therapeutic leaves:

1. The member's record must document the date and time the member leaves the LTC facility and the date and time of return
2. The member may go on a home visit or vacation, to a camp that meets MDH licensure requirements, or to another residential setting **except** another LTC facility, hospital, or other entity eligible to receive Federal,

State, or county funds for his/her maintenance

- The therapeutic leave days must be reported on the claim submitted by the LTC facility with the appropriate therapeutic leave revenue code

Leave day limitations:

Payment for hospital leave days is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. Separate and distinct episode means:

- The occurrence of a health condition that is an emergency
- The occurrence of a health condition that requires inpatient hospital services, but is not related to a condition that required previous hospitalization and was not evident at the time of discharge
- The repeat occurrence of a health condition that is not an emergency, but requires inpatient hospitalization at least two calendar days after the member's most recent discharge from the hospital

MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete payment for therapeutic leave days is limited to the number of days listed below:

- Members in an SNF or NF or certified BCF are entitled to 36 leave days per calendar year.

MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete payment for leave days beyond the 18- or 36-day limit is prohibited, regardless of the occupancy rate. However, the resident or family may opt to pay the LTC facility to hold the bed beyond the MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete benefit period, if the facility offers this special service. If a resident is on leave day status, under most circumstances the facility may not discharge the resident or fill the bed with another resident until after the 18- or 36-day leave period has elapsed, and not at all if the resident has elected to self-pay for days beyond the 18- or 36-day leave period. This policy applies regardless of the facility's occupancy rate. MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete residents who exhaust their hospital leave days and are subsequently discharged from the facility are entitled to be readmitted to the facility to the next available bed.

Note: A 30-day notice may be required before a resident can be discharged due to leave days being exhausted, as provided in [MS 144.652, subd.29](#).

Determining the Number of Leave Days

According to the definition of "leave day," an overnight absence of more than 23 hours is considered a leave day that must be reported. An absence of less than 23 hours on the first day is not a leave day. After the first 23 hours, each time the clock passes midnight counts as an additional leave day. Examples:

LEAVE	RETURN	NUMBER OF LEAVE DAYS
4:30 p.m. Friday	11:30 a.m. Saturday	0 (Less than 23 hours)
4:30 p.m. Friday	5:00 p.m. Saturday	1 (More than 23 hours)
4:30 p.m. Friday	8:00 p.m. Sunday	2 (More than 23 hours; past midnight once)
4:30 p.m. Friday	7:30 a.m. Monday	3 (More than 23 hours; past midnight twice)

Occupancy Rate

Payment for hospital leave and therapeutic leave days are subject to the following occupancy rates:

- LTC facilities with 25 or more licensed beds will not receive payment if the average occupancy rate was less than 96 percent during the month of leave
- LTC facilities with 24 or fewer licensed beds will not receive payment if a licensed bed has been vacant for 60 consecutive days prior to the first leave day (Date of death or discharge will be considered day one when counting consecutive days.)
- The LTC facility charge for a leave day must not exceed the charge for a leave day for a private paying

resident in the same type of bed

The occupancy rate may be calculated separately for each level of care in the facility as follows:

1. Determine the number of days each licensed bed was occupied during the month. (**Note:** A reserved bed is to be considered an occupied bed for this purpose)
2. Total to determine the number of occupied bed days for the month
3. Divide by the number of days in the current month
4. Divide by the number of licensed beds to determine the occupancy rate for the month. For questions on SNF/NF/BCH bed hold and leave day policy, contact PrimeWest Health's Provider Contact Center at **1-866-431-0802** (toll free)

Private (Single Bed) Rooms in NFs

To receive payment from PrimeWest Health for a single bedroom for an MSC+/PrimeWest Senior Health Complete/SNBC/Prime Health Complete member, the following requirements must be met:

1. The member's attending physician must determine and certify that a single bed room is necessary because of a medical or behavioral condition that affects the health of the member or other residents (the estimated length of time the private room is needed must also be indicated)
2. The single bed room must be located in an NF that has chosen to assign a greater proportion of their costs to single bed rooms
3. The bed in the single bed room must be certified for MA by MDH
4. The facility must estimate the length of time the private room is needed
5. The Quality Assessment and Assurance Committee (QAAC) must recommend the single bed room and document the member's condition necessitating the single bed room
6. The attending physician's statement, the QAAC's statement, and any additional relevant documentation from the member's medical record, must be submitted to PrimeWest Health for review, using the [Private Room Request Form](#)
7. If member is age 65 or over, send the completed form by secure email to elaine.carlquist@primewest.org.
8. If member is under age 65, send the completed form by secure email to jennifer.bundy@primewest.org.
9. If member has exhausted his/her 180- or 100-day liability benefit with PrimeWest Health use the [DHS Private Room Request form](#) and send to:
Minnesota Department of Human Services
Nursing Facility Rates and Policy—Private Room Request
Fax: 1-651-431-7466

Swing Bed Hospital Services (NF/Swing Beds)

State law allows MA payments for Swing Bed services provided by a designated licensed hospital, if the following criteria are met:

1. The hospital is the sole community provider, or is a public hospital owned by a government entity with 15 or fewer acute care beds
2. The PrimeWest Health member requires skilled nursing care per Medicaid guidelines
3. A nursing home bed is not available within 25 miles of the facility
4. The patient is transferred from an acute care hospital bed and acute care is no longer needed
5. The person must receive a PAS prior to placement as specified in the *Preadmission Screening* section of this chapter
6. The hospital enrollment criteria, specified in [Requirements for Providers](#), Chapter 1, are met
7. **The [Swing Bed Notification](#) form must be submitted to PrimeWest Health online or by fax to 1-866-431-0804 (toll free).**

Eligible Providers

To be eligible as a Swing Bed provider in the MA program, a provider must accomplish the following:

1. Receive Medicare certification as a Medicare Swing Bed provider. Medicare certification requires a survey by MDH. Certification information may be obtained from:
Minnesota Department of Health (MDH) Facility and Providers Compliance Division
85 E 7th Place
P.O. Box 64900
Saint Paul, MN 55164
1-651-215-8701
2. Sign a Swing Bed Provider Agreement with DHS. Provider agreement information may be obtained from:
Minnesota Department of Human Services
Nursing Home Rates and Policy
P.O. Box 64973
Saint Paul, MN 55164-0973

Exceptions: Swing Bed services may be billed by a hospital not enrolled in the MA program only in the case of a Qualified Medicare Beneficiary (QMB) receiving PrimeWest Senior Health Complete/Prime Health Complete Swing Bed services. Coinsurance and deductible on QMB claims will be paid for the length of the PrimeWest Senior Health Complete/Prime Health Complete approved stay. PrimeWest Health also covers up to 10 days of nursing care provided to a member in a Swing Bed if all of the following are met:

1. The member's physician certifies that the member has a terminal illness or condition that is likely to result in death within 30 days and moving the member would not be in the best interests of the member and the member's family
2. A nursing home bed is not available within 25 miles of the facility
3. An open bed is not available in any Medicare hospice program within 50 miles of the facility

Eligible Members

To be eligible for Swing Bed payment, there must be documentation that the member requires a level of skilled nursing care consistent with admission to an LTC facility and no longer requires acute care hospital services. If the need for skilled nursing care cannot be documented, the services are not eligible for PrimeWest Health payment. A copy of the preadmission document must be attached to the claim.

Preadmission Screening (PAS)

All people seeking placement in a Swing Bed must be screened either through a community screening or through a telephone screening prior to admittance to a swing bed in accordance with the policy described in the *Preadmission Screening* section of this chapter. Exceptions to PAS in Swing Bed placement are for the following:

1. People admitted from the community on a physician certified emergency basis or people admitted on a county non-working day must be screened on the first county working day after admission;
2. People returning to a Swing Bed who entered an acute care facility from a Swing Bed
3. People in a swing bed who are transferring to another Swing Bed in another facility
4. People who have a contractual right to have their Swing Bed services paid for by the Veterans Administration
5. People who are enrolled in the Ebenezer/Group Health Social HMO Project at the time of application to the Swing Bed

Limitations

In accordance with State law, payment for Swing Bed services for a PrimeWest Health member is limited to 40 days, unless the Commissioner of MDH grants an extension. Approval for services in excess of 40 days must be

requested in writing from MDH at least 10 days before the end of the maximum 40-day stay. The extension approval must be attached to claims, which include service dates beyond the initial 40-day period. Eligible hospitals are allowed a total of 1,460 days of Swing Bed use per the State's fiscal year (July 1 – June 30), provided that no more than 10 hospital beds are used as Swing Beds at any one time.

Ancillary Services

Routine care and services, similar to those provided in an NF, are included in the daily Swing Bed payment rate. All other covered services may be billed to PrimeWest Health. All ancillary services must be billed in accordance with the respective guidelines for the service, as outlined in the appropriate chapters of this manual.

Billing Guidelines

1. Room and board services must be billed in the 8371 format using the facility's National Provider Identifier (NPI). The type of bill must be 281.
2. The daily room and board payment rate for Swing Bed services is set by law as the statewide average payment rate of all MA nursing facilities' per diem. This rate is computed annually, effective each July 1.
3. Only non-over-the-counter (OTC) PrimeWest Health formulary pharmacy services can be billed outside the room and board per diem. Stock medications and OTC products are not separately reimbursable.
4. Ancillary services for PrimeWest Senior Health Complete/Prime Health Complete-eligible members must be billed to PrimeWest Health. If the services are not covered by Medicare, PrimeWest Health may be billed under the member's Medicaid benefit.
5. Ancillary services for Medicare-eligible members not on a PrimeWest Health Medicare Advantage Plan must be billed to Medicare. If the services are not covered by Medicare, PrimeWest Health may be billed under the member's Medicaid benefit.
6. 210 Bill type PrimeWest Senior Health Complete/Prime Health Complete members – No need for this because PrimeWest Health pays both portions of the claim (Medicare and Medicaid).
 - a. The 60-day break in spell of illness will be tracked by the [Skilled Nursing Facility Notification Form](#).
7. Demand Bill: Member is entitled to receive one if he/she requests it.
8. Shadow Billing: Medicare requires a claim for skilled days to track the number of days used. This will need to be submitted to CMS.

Equalization

State law prohibits LTC facilities from charging private-pay residents higher rates than those approved by DHS for Medicaid recipients. The law also allows residents to be awarded three times the payments that result from a violation. For more information on Equalization and Special Services, refer to the section in this Chapter on *Special Services*.

Exceptions

1. The Equalization Law does not apply to third party payers
2. The Equalization Law may or may not apply to private paying residents in single bed rooms, depending on the cost allocation method for single bed rooms chosen by the facility on their annual cost report

Conditions of Participation

Termination of Provider Agreement

An LTC facility that chooses not to comply with the Equalization Law may voluntarily withdraw or involuntarily be withdrawn from the Medicaid program. Under most of these circumstances, the provider becomes ineligible to

receive payment under other State and county programs. Special laws apply to NF providers that withdraw from the Medicaid program (contact Nursing Home Rates and Policy at **1-651-431-2281** for more information). If discharge of residents is necessary, discharge planning and relocation must be done in accordance with all provisions of State and Federal Resident Rights and the State Resident Relocation Law.

Segregation of Medicaid Residents

Partial certification or de-certification of a distinct part of an NF may result in the segregation of MA residents. These practices discriminate against residents based on their source of funding and may violate both the Equalization Law and anti-discrimination laws. DHS will not enroll facilities that stigmatize residents receiving public assistance or practice other forms of resident discrimination. LTC facilities that intend to or have segregated MA residents will be investigated by DHS.

Solicitation of Contributions

Federal law prohibits soliciting contributions, donations, or gifts directly from MA residents or family recipients. General public appeals for contributions are not considered direct solicitation of MA residents or families. If an MA resident or family member makes a free-will contribution, the LTC provider is required to execute a statement for signature by the contributor and the LTC administrator, stating services provided in the LTC facility are not predicated upon contributions or donations and the gifts are free-will contributions.

Change of Ownership

The Social Security Act requires an LTC facility to promptly report any organizational or ownership changes to the MDH to maintain enrollment with PrimeWest Health.

MDH will determine if the LTC facility continues to meet minimal State and Federal standards under new ownership. MDH will submit copies of the certification to the LTC facility, PrimeWest Health, and the county.

If PrimeWest Health receives notification that an entity has changed ownership, PrimeWest Health will follow up with the provider to see if the provider wants to continue to be part of the PrimeWest Health network. If the provider does, PrimeWest Health will send them the appropriate documents to reflect the change. Once PrimeWest Health has received the appropriate documents, it will inactivate the old “owner” and make a new entry in PMA with the new/updated information with the effective date of the change.

According to State law, the owner of the LTC facility is liable for any overpayment amount owed by a former owner for any facility sold, transferred, or reorganized.

Resident Trust Account

Administration of Resident Fund Accounts

An LTC facility resident may deposit his/her funds, including the personal needs allowance established under Minnesota Statutes, in a resident fund account administered by the facility. An LTC facility must comply with MDH regulations concerning resident funds in addition to the following provisions:

1. Credit to the account all funds attributable to the account including interest and other forms of income
2. Do not co-mingle resident funds with the funds of the facility
3. Keep a written record of the recipient’s resident fund account, including the date, amount, and source of deposit or withdrawal recorded within five working days of the account activity
4. Require a recipient who withdraws \$10.00 or more at one time to sign a receipt for the withdrawal. A withdrawal of \$10.00 or more that is not documented by a receipt must be credited to the recipient’s account.

- Receipts for the actual item purchased for the recipient's use may substitute for a receipt signed by the recipient.
5. Do not charge the recipient a fee for administering the his/her account
 6. Do not solicit donations or borrow from a resident fund account
 7. Report and document to the county a recipient's donation of money to the facility when the donation equals or exceeds the statewide average MA payment for SNF care
 8. Do not use resident funds as collateral for or payment of any obligations of the facility
 9. Treat funds remaining in a recipient's account upon death or discharge as required by MDH regulations

Limitations on Use of Trust Funds

Funds in the member's resident fund account must **not** be used to purchase the following items or services generally reported in the facility's cost report:

1. Medical transportation
2. Initial purchase or replacement purchase of furnishings or equipment required as a condition of certification as an LTC facility
3. Laundering the member's clothing
4. Furnishings or equipment not requested by the member for personal convenience
5. Personal hygiene items necessary for daily personal care (e.g., bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, razor, facial tissues)
6. OTC drugs or supplies used by the member on an occasional, as needed basis, not prescribed for long-term therapy of a medical condition (e.g., aspirin, acetaminophen, antacids, anti-diarrheas, cough syrups, rubbing alcohol, talcum powder, body lotion, petroleum jelly, mild antiseptic solutions, etc.)

These limitations do not prohibit the member from using his/her funds to purchase a brand name supply or other furnishings not routinely supplied by the LTC facility.

Questions on LTC policy and services may be directed to the PrimeWest Health Provider Contact Center at **1-800-431-0802** (toll free).

Legal References

[MS 144.562, subd. 2 & 3](#)

[MS 256B.27, subd. 1](#)

[MS 256B.0625, subd. 2](#)

[MS 256B.0911](#) (section 5-LTCC)

[MN Rules parts 9505.2390 – 9505.2500](#) (Rule 65)

[MS 256B.48](#) (Section 8: 186)

[MS 256B.501](#), subd. 8; 8a

[MN Rules parts 9510.1020 – 9510.1140](#) (Rule 186)

[MN Rules part 9549.0060](#), subp. 11

[MN Rules part 9549.0070](#) subp. 3