Chapter 27

Long Term Care

Long term care (LTC) facilities provide medical and supportive services for residents who:

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

Questions on LTC facilities, policy and services can be directed to:

Long Term Care Policy Center
(651) 431-2282

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 which is licensed to provide nursing care for persons 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 ICF/MR; must admit and care for those MA recipients certified as requiring the same level of care as the bed certification.

Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR): A facility licensed to serve persons who have mental retardation or related conditions, as a supervised living facility under MN Statutes, Ch. 144 and certified by the Minnesota Department of Health (MDH) as an intermediate care facility for the mentally retarded.

LTC Facility: A residential facility certified by the MDH as a skilled nursing facility or as an intermediate care facility, including an ICF/MR.

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 recipient occupied before leaving the facility for hospital leave or therapeutic leave, or an appropriately certified bed if the recipient'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 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 resident, for whom a bed is being held, to an inpatient hospital.

Eligible Providers

Psychiatric hospitals, skilled nursing facilities (SNF), nursing facilities (NF), boarding care homes (BCH), and intermediate care facilities for people with mental retardation or related conditions (ICF/MR) certified by Minnesota Department of Health (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 MA recipients certified as requiring the same level of care as the bed certification.

Exemption: An SNF, ICF or ICF/MR 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 MA payments for the cost of recipient care.

Eligible Recipients

LTC facilities provide services to elderly people, persons with disabilities, and persons with mental retardation and related conditions.

MSC+ or MSHO eligible recipients must reside in a certified bed that matches his or her certified level of care.

PWH will cover the cost of care for a recipient who resides in a certified NF, certified BCH, or licensed ICF/MR if the following requirements are met:

Certified Nursing and Certified Boarding Care Facility:

- The care is ordered by a physician;
- The care is provided in compliance with MDH; and
- The care provided in an NF or BCH is required because of physical or mental limitations determined through the long term care consultation process completed by the county, prior to admission to the facility, with certain exceptions defined below.

Intermediate Care Facility for the Mentally Retarded:

- The recipient meets admission criteria as determined by the admission review team, based on the preliminary evaluation prior to admission;
- The recipient is in need of and receives active treatment;
- The recipient's active treatment program is integrated, coordinated and monitored by a qualified mental retardation professional.

Each ICF/MR provider agency is responsible to meet all federal, state and local requirements.

Swing Bed Hospital:

- 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 boarding care facility, or ICF/MR. A DHS-1503 form must be completed in the following instances:

- Upon initial admission or upon readmission following discharge;
- When a recipient transfers from one LTC facility to another;
- When a recipient transfers within a facility from a NF1 (SNF/NF) to a NF2 (Certified Boarding Care Home) level of care;
- When a recipient returns from an unauthorized leave exceeding 24 hours; and
- When a recipient returns from hospitalization, if their 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:

- **Recipient:** 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.
- **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.

Physician Recertification for ICF/MR Recipients

The Physician Recertification Form (DHS-1743) must be completed annually and at least 30 days after the completion of form DHS-1503.

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 the Physician & Professional Services chapter (Ch. 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 recipient'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

As of October 1, 2002, the new Minnesota case-mix system, known as the **RUG III 34 model** was adopted. This model uses an existing federally mandated assessment instrument for all nursing facility residents.

Facilities must conduct and electronically submit to the Department of Health a case-mix assessment for all residents.

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

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

Request for Reconsideration of Resident Classification

The resident, resident's representative, or the nursing facility or boarding care home may request that the Department of Health 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 a reconsideration, the request must be submitted in writing to the Minnesota Department of Health 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
St Paul, MN 55164-0938
651/201-4301

Medical/Social Evaluation (ICF/MR Only)

Each recipient must have a medical evaluation whenever a DHS-1503 is required. The minimum requirements of this evaluation are:

- Diagnosis, symptoms, complaints/complications, present medical/developmental findings, and medical/social family history;
  - Mental/physical functioning levels;
  - Prognosis;
  - Range of needs, objectives, and plans for continuing care;
  - The physician's recommendation for admission;
- Alternatives to LTC available in the home, family, and community; and
- Results of a psychological evaluation performed within three months prior to admission (not required upon return from hospitalization).

In the situation where a recipient is readmitted from a hospital stay or unauthorized leave, it is required to document the review and any update of the evaluation.

Overall Plan of Care (ICF/MR Only)

Each recipient must have an individual plan of care developed by an interdisciplinary team with representation from the professions, disciplines or service areas specific to the individual needs and program design.

The plan must be based on the results of a comprehensive functional assessment as defined by federal regulations.

The plan must state the objectives needed to meet the individuals' needs as identified by the comprehensive assessment and document a sequenced plan for meeting the objectives. The

objectives must:

- Be stated separately, in terms of a single behavioral outcome.
- Be assigned projected completion dates.
- Be expressed in behavioral terms that provide measurable indices of performance.
- Be organized to reflect a developmental progression appropriate to the individual.
- Be assigned priorities.

The plan must describe relevant interventions to support the individual toward independence. The interventions must:

- Identify the location where program strategy information can be found.
- Include training in personal skills essential for privacy and independence, if the individual lacks them.
- Identify the need for mechanical supports to achieve proper body position, balance or alignments, when they are to be applied, and a schedule for the use of each support.
- Provide that individuals who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area.
- Include opportunities for individual choice and self-management.

The plan must be completed within 30 days after admission.

The plan must be reviewed by the QMRP as needed and when the individual:

- Has successfully completed an identified objective(s).
- Is regressing or losing skills already gained.
- Is failing to progress toward identified objectives after reasonable efforts have been made.
- Is being considered for training towards new objectives.

The plan must be reviewed and documented by the interdisciplinary team, per case management dictates.

Utilization Review (ICF/MR Only)

The initial utilization review date for a recipient must be established at the time of admission and documented on the DHS-1503. The initial utilization review date for an MA applicant must be established when notified of MA eligibility.

The Utilization Review Group documentation must indicate the recipient has been reviewed at least every six months, or more often if the group deems it necessary.

Each time a DHS-1503 is required, the utilization review process must be re-established.

Nursing Assistant (NA) Registry

Nursing Assistant Training and Competency Evaluation

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

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

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

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

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

- Is competent to provide nursing and nursing-related services; and
- 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 NA 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 NA 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, Suite 300
P.O. Box 64501
St. Paul, MN 55164-0501
(651) 215-8705 or 1-800-397-6124

Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact DHS.Long Term Care Policy Center (651) 431-2282

PreAdmission Screening (PAS) Under State and Federal Statutes

Minnesota statutes and federal law require that all applicants to certified nursing facilities, 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 nursing facility 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 nursing facility admissions. The purpose of the consultation (screening) activity is to determine the need for nursing facility 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 nursing facility if the individual does not meet the nursing facility 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 retardation (and subsequent referrals for more completed evaluation as needed) are limited to:

- A person who, having entered an acute care facility from a certified nursing facility, is

returning to a certified nursing facility;

- A person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.
- Certain hospital discharges when:
  - The person is entering a certified nursing facility directly from an acute care hospital after receiving acute inpatient care at the hospital; and
  - The person requires NF services for the same condition for which he or she received care in the hospital; and
  - 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 long term care consultation.

Preadmission Screening (PAS)for NF Level of Care Determination

The determination of the need for nursing facility 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: Persons who are exempt from preadmission screening for purposes of level of care determination include:

- Persons exempt under the federal requirements related to screening for mental illness or mental retardation as outlined above;
- An individual who has a contractual right to have nursing facility care paid for indefinitely by the veteran's administration;
  - 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, subdivision 8, at the time of application to a nursing facility;
- An individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the Social Security Act; or
- An individual admitted to a certified nursing facility for a short-term stay, which, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for nursing facility 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 nursing facility 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 a 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.

Preadmission Screening (PAS) and Medical Assistance Reimbursement

Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a PAS has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any member who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had an evaluation completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

The nursing facility shall not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under state and federal law. The nursing facility must include an un-reimbursed resident day in the nursing facility resident day totals reported to DHS.

See MS 256B.0911 and Minnesota Rules 9505.2450 for authority for these payment limitations.

Emergency Admissions

Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis as described in (1), or from an acute care facility on a nonworking day must be screened the first working day after admission.

Emergency admission to a nursing facility prior to screening is permitted when a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours and:

- The physician has determined that delaying admission until long term care consultation is completed would adversely affect the person's health and safety.
- There is a recent precipitating event that no longer enables the client 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.
- 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 a nursing facility 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 summarized timelines and other requirements for long term care consultation as well as some follow-up activity performed by county Long Term Care Consultation staff.

TIMELINES FOR PAS & ASSESSMENTS FOR NURSING FACILITY ADMISSIONS	Preadmission Screening	
	Under 65	Over 65
Hospital Discharge: NF Admission Meets Criteria for a 30-Day Exemption	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 40th Day of Admission: Face-to-face LTCC visit, OBRA Level 1, any needed OBRA Level 2	By 40th 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 work day after admission LTCC visit within 20 working days of admission if telephone screen	Next work day after admission
Initial screening after emergency NF admission	Next work day after admission LTCC visit within 20 working days of admission if telephone screen	Next work 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 persons age 21 to 64 admitted to NF if admitted by telephone screening	Within 20 work days of admission	--

County Responsibility

- 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.
- 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.
- Under most circumstances, the "county of location" is responsible for **PAS** for recipients requesting admission to a certified nursing facility or certified boarding care facility.
- If the person leaves a correctional facility (on medical release) to enter a NF, the person must be screened by the county in which the prison is located.
- If the person is being discharged from the hospital to the nursing facility, contact the county in which the hospital is located.

Nursing Facility and Boarding Care Home Responsibility

NFs' and certified boarding care facilities' responsibilities under the PAS program include the following:

- Determining if applicant has been screened;
- Informing applicants of **PAS** program requirements and background;
- Obtaining consent for **PAS** and notifying the county; and
- 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.**

The LTC facility should retain the following documents:

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

Medicare Revenue Enhancement Program (MREP)

The Medicare Revenue Enhancement Program (MREP) recovers MA funds and identifies other areas of savings to the MA program. MREP also appeals denied MSHO benefits in cases where MSHO should cover the services.

MREP Process

- LTC staff initially determines MSHO coverage.
- A resident that has been denied MSHO coverage upon admission to the LTC facility, or is no longer coverable under MSHO, must be given a written denial notice by the LTC facility.
- LTC facilities may be required to refer cases to MREP when:
  - The resident is an MA recipient;
  - MA eligibility is pending; and
  - The resident is MA eligible and has MSHO through PrimeWest Health.

To request information or obtain instructions for the referral process, contact:

Medicare Revenue Enhancement Program
Department of Human Services
P.O. Box 64995
St. Paul, MN 55164-0995
Phone numbers: (651) 431-3151 or (651) 1-800-657-3963
Fax: (651) 431-7431

Referral and Screening Process

The LTC facility must complete the steps listed below for referral and screening MSHO/MSC+ eligible recipients:

- The LTC facility determines MSHO coverage on admission and/or continued stay.
- The LTC facility must submit the above information to MREP within four weeks of denial.
- MREP screens the case for MSHO eligibility and MSHO skilled level of care/skilled services.
- DHS requests a specific demand bill from the LTC facility, if applicable.
- The NF completes Medicare demand bill and submits to PrimeWest Health with paperwork required by the next billing cycle. The LTC facility may reverse the original decision and submit a covered claim in place of a demand bill.
- PrimeWest Health receives the resolution of demand bills, reviews cases for further appeal, and will recover funds from LTC facility. If MSHO did not cover the entire month, the SNF must submit a claim to DHS for the non-covered days.
- DHS screens appealable cases for cost effectiveness. If cost effective, cases are referred for reconsideration and an administrative law judge (ALJ) hearing.
- DHS receives results of the reconsideration, including justification for denial. If the decision is reversed, the LTC facility must submit a claim to PrimeWest Health with the proper documentation.
- DHS pursues ALJ hearings. If the decision is reversed, the LTC facility will be paid by completing a payment adjustment.

The PrimeWest Health appeals process does not require a demand bill be sent. Once services are denied by the 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 the PrimeWest Health made its determination not to cover the stay. It is very important to send the MREP denial referral as soon as the provider knows the skilled nursing facility has denied the stay, or part of the stay.

Covered Services

PrimeWest Health covers room and board care for an MA recipient in a certified NF, certified boarding care facility or ICF/MR. 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):

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

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

MA covers the majority of costs incurred while in a nursing facility. However, a resident may be responsible for some non-covered MA services, such as:

- Special Services;
- Other services not covered by MA; and
- 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:

- The facility must provide a detailed explanation of what is included in the case-mix rate;
- The facility must provide a detailed explanation of the special service and the additional charge;
- 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;
- The service cannot be a licensure or certification requirement;
- Each resident or potential admission must be free to choose whether or not he/she desires to purchase the special service from the facility; and
- 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:

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

Rehabilitative Services

Long-term care 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 the Rehabilitative Services chapter (Ch. 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 MSHO requires the LTC facility to do the billing for MSHO covered rehabilitative services for dually eligible recipients, you must follow MSHO's requirements until MSHO benefits are exhausted.

Leave Days (SNF/NF/BCH)

Leave days are eligible for MSC+/MSHO payment. A leave day must be for hospital leave or therapeutic leave of a recipient who has not been discharged from an LTC facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave. Payment for leave days in an SNF or NF is limited to 60% of the applicable payment rate.

To be eligible for MSC+ payment, the following criteria must apply:

Hospital leaves:

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

Therapeutic leaves:

- The recipient's record must document the date and time the recipient leaves the LTC facility and the date and time of return;
- The recipient 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; and
- 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 which required previous hospitalization and was not evident at the time of discharge; or
- The repeat occurrence of a health condition that is not an emergency, but requires inpatient hospitalization at least two calendar days after the recipient's most recent discharge from the hospital.

MSC+ payment for therapeutic leave days is limited to the number of days listed below:

- Recipient s in an SNF or NF or certified boarding care facility are entitled to 36 leave days per calendar year.

MSC+ 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+ 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+ residents that 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.

Intermediate Care Facilities for Mental Retardation (ICF/MR)

For information on ICF/MR therapeutic leave day policy and payment, go to http://edocs.dhs.state.mn.us/lfserver/legacy/dm-0015-eng.

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 93% 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.); and
- 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:

- 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.)
- Total to determine the number of occupied bed days for the month;
- Divide by the number of days in the current month; and
- 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:

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

For questions regarding ICF/MR occupancy, contact: dhs.icf.occupancy@state.mn.us

Private (Single Bed) Rooms in NFs

To receive payment from PrimeWest Health for a single bedroom for a MSC+ recipient, the following requirements must be met:

- The recipient'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 recipient or other residents (the estimated length of time the private room is needed must also be indicated);
- The single bed room must be located in an NF which has chosen to assign a greater proportion of their costs to single bed rooms;
- The bed in the single bed room must be certified for MA by the MDH;
- The Quality Assessment and Assurance Committee (QAAC) must review the attending physician's recommendation for the single bed room, and sign a statement that a single bed room is required; and
- The attending physician's statement, the QAAC's statement and any additional relevant documentation from the recipient's medical record, must be submitted to PrimeWest Health. for review.
- If a recipient is in the 180 day liability benefit period, mail to:

  PrimeWest Health

  SNF-Senior Care Coordinator

  2209 Jefferson Street, Suite 101

  Alexandria, MN 56308

  AND

  To DHS if the enrollee has exhausted their 180 day liability benefit with PrimeWest Health

- Mail the above information to: *If a recipient is in the 180 day period Mail to:

  Department of Human Services
  Nursing Home Rates and Policy
  Attn: Kent DuFresne
  P.O. Box 64973

St. Paul, MN 55164-0973

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:

- The hospital is the sole community provider, or is a public hospital owned by a government entity with 15 or fewer acute care beds;
- The MA patient requires skilled nursing care per Medicaid guidelines;
- A nursing home bed is not available within 25 miles of the facility;
- The patient is transferred from an acute care hospital bed and acute care is no longer needed;
- The person must receive a long term care consultation prior to placement as specified in the Long term care consultation section of this chapter; and
- The hospital enrollment criteria, specified in the Requirements for Providers chapter (Ch. 1) are met.
- Must submit a PMAP or MSHO communication form to PrimeWest Health by fax to 866-431-0804.

Eligible Provider

To be eligible as a swing bed provider in the MA program, a provider must accomplish the following:

Receive Medicare certification as a Medicare swing bed provider. Medicare certification requires a survey by the MDH. Certification information may be obtained from:

Minnesota Department of Health (MDH)
Facility and Providers Compliance Division
85 East 7th Place
P.O. Box 64900
St. Paul, MN 55164
(651) 215-8701

- 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
  St. 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 MSHO swing bed services. Coinsurance and deductible on QMB claims will be paid for the length of the MSHO approved stay. MA also covers up to 10 days of nursing care provided to a patient in a swing bed if:

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

Eligible Recipients

To be eligible for swing bed payment, there must be documentation that the recipient 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 MA payment. A copy of the long term care consultation document must be attached to the claim.

Long Term Care Consultation (LTCC) (Preadmission Screening)

All persons 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 Long Term Care Consultation **(LTCC)** section of this chapter. Exceptions to
LTCC in swing bed placement are:

- Persons admitted from the community on a physician certified emergency basis or persons admitted on a county non-working day must be screened on the first county working day after admission;
- Persons returning to a swing bed who entered an acute care facility from a swing bed;
- Persons in a swing bed who are transferring to another swing bed in another facility;
- Persons who have a contractual right to have their swing bed services paid for by the Veterans Administration; and
- Persons 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 an MA recipient 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 ten 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 to 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

- Room and board services must be billed in the UB-04 format using the hospital's provider number. The type of bill must be 281.
- 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.
- Only non-over-the-counter (OTC) PWH formulary pharmacy services can be billed outside the room and board per diem. Stock medications and OTC products are not separately reimbursable.
- Ancillary services for MSHO eligible people must be billed to PWH. If the services are not covered by MSHO, PrimeWest Health may be billed.

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

- The Equalization Law does not apply to third party payers; and
- 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

A 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 Nursing Facility providers that withdraw from the Medicaid program (contact Nursing Home Rates and Policy at (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 a LTC facility to promptly report any organizational or ownership changes to the Minnesota Department of Health (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.

When PrimeWest Health receives notification of change of ownership, the Provider Enrollment Unit will terminate the PrimeWest Health provider number assigned to the previous owner. The new owner must submit a new application and agreement to the Provider Enrollment Unit for a new PrimeWest Health provider number.

DHS will forward the new PrimeWest Health provider number to the county. The county will update its records and reassign MA recipients with the new provider number.

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

A 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:

- Credit to the account all funds attributable to the account including interest and other forms of income;
- Not co-mingle resident funds with the funds of the facility;
- 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;
- 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;
- Not charge the recipient a fee for administering the his/her account;

- Not solicit donations or borrow from a resident fund account;
- 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;
- Not use resident funds as collateral for or payment of any obligations of the facility; and
- 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 recipient's resident fund account must **not** be used to purchase the following items or services generally reported in the facility's cost report:

- Medical transportation;
- Initial purchase or replacement purchase of furnishings or equipment required as a condition of certification as an LTC facility;
- Laundering the recipient's clothing;
- Furnishings or equipment not requested by the recipient for personal convenience;
- Personal hygiene items necessary for daily personal care (e.g., bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, razor, facial tissues); and
- Over the counter drugs or supplies used by the recipient 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 recipient 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:

Nursing Home Rates and Policy
Department of Human Services
P.O. Box 64973
St. Paul, MN 55164-0973
(651) 431-2281

Legal References

MS 144.562, subd. 2 & 3
MS 256B.27, subd. 1
MS 256B.0625, subd. 2
MS 256B.0911 (section 5-LTCC)
Minnesota Rules 9505.2390 to 9505.2500 (Rule 65)
MS 256B.48 (Section 8: 186)
MS 256B.501, subd. 8; 8a
Minnesota Rules 9510.1020 to 9510.1140 (Rule 186)
Minnesota Rules 9549.0060, subp. 11
Minnesota Rules 9549.0070 subp. 3.