Chapter 27

Long-Term Care (LTC)

Long-term care facilities (LTCFs) 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

Definitions

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

Certified Nursing Facility: 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 nursing facility that is documented in the discharge summary and signed by the physician.

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

Long-Term Care Facility (LTCF): A residential facility certified by the Minnesota Department of Health (MDH) as a Skilled Nursing Facility (SNF) or as an Intermediate Care Facility (ICF), 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.”

Residential Facility: Facility in which residents live in a group setting at a location that is not a single-family home or medical institution.

Skilled Nursing Facility (SNF): A licensed facility that provides skilled nursing care for acute and chronic conditions as well as additional help for activities of daily living (ADL).

Swing Bed: A hospital bed that has been granted a license under MN Stat. sec. 144.562 and which has been certified to participate in the Federal Medicare program under Title 42 United States Code (USC) Section 1395. Refer to the Swing Bed section of this chapter.

Transfer: The movement of a member after admission from one facility directly to another facility with a different provider number, or to or from a unit of a hospital to another unit recognized as a rehabilitation-distinct part by Medicare. Transfer also includes members who move to or from extended inpatient psychiatric services capacity under contract with the Minnesota Department of Human Services (DHS). Moving a member from a medical or surgical service to the acute psychiatric unit within the same hospital is not considered a transfer and must be billed as one continuous hospitalization.
Eligible Members

LTCFs provide services to elderly people, people with physical disabilities, and people with developmental disabilities and related conditions. These individuals have been screened and determined to need a nursing facility level of care.

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 their certified level of care.

Nursing facility level of care can be determined through a face-to-face assessment conducted by a lead agency (county, tribe, or managed care organization) with the authority to determine eligibility for the programs listed as specified under Minnesota Stat. sec. 256B.0911 governing Long Term Care Consultation Services (LTCCS). Nursing facility level of care is also determined through preadmission screening as described in Minnesota Stat. sec. 256.975. The Nursing Facility Level of Care Criteria document can also be used to assist in determining eligibility for long-term care.

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

Certified Nursing Facility and Certified Boarding Care Home (BCH):
1. The care is ordered by a physician
2. The care is provided in compliance with State and Federal regulations
3. The care provided in a nursing facility or BCH is required because of physical or mental limitations determined through the Preadmission 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
Specifications are in the Swing Bed section of this chapter

Utilization Control

Physician Certification

A physician must certify the need for a certified nursing facility or certified boarding care facility. 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 nursing facility to another
3. When a member transfers within a nursing facility from one level of care to another
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 facility 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.
Physician Visits for Nursing Facility and Boarding Care Members

Under State Rule, a certified nursing facility 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 member on a 60-day schedule of visits is transferred to a hospital and returns to the same nursing facility, 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 member 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 (PA), certified nurse practitioner (CNP), or Clinical Nurse Specialist (CNS). The PA, CNP, or CNS must not be an employee of the nursing facility.

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 LTCFs) 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 MN Stat. sec. 144A.161.

Same Day Transfers

When a member is transferred from one facility to another facility before midnight of the same day, the condition code of 40 must be assigned to the claim or the claim will be denied.

The original provider must bill as follows:
1. Indicate “0” in Covered Days;
2. Insert condition code 40 to indicate the member was transferred from one participating provider to another before midnight on the day of admission; and
3. Ensure that the admission date and statement “from” and “through” dates are the same.

Resident Classification

The case mix system utilized for Minnesota nursing facilities (NFs) certified for Medical Assistance (Medicaid) is based on the Federally required minimum data set (MDS), version 3.0. The RUGS-III, 34-group model was modified to 36 groupings and used to establish Minnesota case mix classifications. These case mix classifications, in part, determine the per diem (daily) rates for residents residing in Minnesota NFs.
The facility must conduct the following resident assessments in accordance with the most current CMS guidelines, and use them in determining a resident’s case mix classification for reimbursement purposes:

1. Admission assessment
2. Annual assessment
3. Significant change assessment
4. Quarterly assessments
5. Significant correction to prior comprehensive assessment
6. Significant correction to prior quarterly assessment

NFs conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). MDH then determines the resident’s case mix classification based on the MDS data and notifies the facility, who in turn notifies the resident. MDH also transmits this data to the Minnesota Department of Human Services (DHS), for use in determining the facility’s reimbursement (per diem) rates. MDH also conducts regular audits of the MDS data submitted by NFs to ensure the data are accurate. Audits conducted by MDH may result in changes to the resident’s case mix classification and therefore the resident’s per diem rate. The nursing facility or the resident may request a reconsideration of the case mix classification from MDH. MDH conducts case mix-related functions on behalf of the Medicaid program under contract to DHS (the Medicaid agency).

MDH sends the case mix file to DHS every Tuesday and it is held so it can be verified and examined before being loaded into Medicaid Management Information System (MMIS). During review, if the case mix file is found to be inaccurate, the file is deleted for that week. DHS will receive no case mix records from MDH until the following week, which would also include any records not received previously.

For more information on Minnesota case mix for nursing facilities, review MDH’s Minnesota Case Mix Review Program web page.

**Request for Reconsideration of Resident Classification**

The resident, resident’s representative, or the nursing facility or BCH may request that MDH reconsider the assigned reimbursement classification. Residents or their representatives have the right to review the minimum data set (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
  - PO Box 64938
  - Saint Paul, MN 55164-0938

  - Phone: **1-651-201-4301**
  - Fax: **1-651-215-9691**
  - Email: [Health.FPC-CMR@state.mn.us](mailto:Health.FPC-CMR@state.mn.us)

**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.

**Nursing Assistant Registry**

**Nursing Assistant Training and Competency Evaluation**

An LTCF 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 LTCF 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 LTCF 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 LTCF 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
  PO Box 64501
  Saint Paul, MN 55164-0501

  Phone: 1-651-215-8705 or 1-800-397-6124 (toll free)
  Email: Health.FPC-NAR@state.mn.us

Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact:
  Long Term Care Policy Center
  Phone: 1-651-431-2282
  Email: DHS.LTCpolicycenter@state.mn.us

Preadmission Screening (PAS) Under State and Federal Statutes

Minnesota Statutes and Federal law require that all individuals entering a Medical Assistance (Medicaid)-certified nursing facility, hospital Swing Bed, or certified boarding care facility receive PAS, regardless of the length of stay or payer source for facility services.

The purpose of the PAS process is to avoid unnecessary facility admissions by identifying individuals whose needs might be met in the community and who can be connected with community-based services. PAS helps determine and document the need for certified nursing facility, hospital Swing Bed, or certified boarding care facility services in Medicaid Management Information System (MMIS) for the purpose of Medical Assistance (Medicaid) payment for services and to provide assistance after facility admission to support the transition back to community life. PAS also serves to screen people for mental illness or developmental disabilities (OBRA Level I). The screening is completed to identify and refer individuals to other professionals for additional diagnosis and evaluation (OBRA Level II) of the need for specialized mental health or developmental disability services as required under Federal law.

The Senior LinkAge Line® is responsible to perform PAS for all individuals except those enrolled in the following Minnesota Health Care Programs (MHCP):
1. Minnesota Senior Health Options (MSHO)
2. Minnesota Senior Care Plus (MSC+)
3. Special Needs BasicCare (SNBC)

All PAS referrals must be submitted online by a qualified health care professional at www.mnaging.org. The qualified health care professional must have sufficient information to complete the online screening tool. Referrals for PAS should not be sent directly to PrimeWest Health. The Senior LinkAge Line® will retrieve the referral information and forward the PAS request for individuals enrolled in PrimeWest Senior Health Complete (HMO SNP), MSC+, Prime Health Complete (HMO SNP), or SNBC to PrimeWest Health via secure email. This information is forwarded to the local agency for completion of the necessary actions required by State and Federal statutes.
The local agency will use forms and criteria developed by the commissioner to identify individuals who require referral for further evaluation and determination of the need for specialized services. The screener will consult with care transition coordinators, physicians, and/or other personnel deemed necessary to determine the appropriate level of care.

**Minnesota Department of Human Services (DHS) Approval Required for All Individuals Age 21 and Under and/or for All Individuals with a Developmental Disability**

DHS must approve all admissions for individuals age 21 and under and all admissions of individuals with developmental disabilities, regardless of the exemptions outlined below or responsibilities of the Senior LinkAge Line®/local agency outlined above. DHS approval is required regardless of the source of admission or payer for facility services.

**Individuals Under 21 Years of Age**

For all individuals under age 21, a face-to-face assessment must occur before admission to a certified nursing facility, hospital Swing Bed, or certified boarding care facility, regardless of expected length of stay or admission source. This requirement is intended to prevent admission of this population whenever possible by developing community-based support and care plans that will meet the individual’s needs in a less restrictive environment.

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 certified nursing facility, hospital Swing Bed, or certified boarding care facility admission cannot be prevented, the admission must be approved by DHS by calling 1-651-431-2441.

**Individuals with a Developmental Disability**

Admission of an individual with a developmental disability to a certified nursing facility, hospital Swing Bed, or certified boarding care facility must also be approved by DHS and will include an approved length of stay. The lead agency will obtain the approval from DHS by completing the required actions outlined in DHS Bulletin # 14-25-11.

**Exemption from Level of Care Determination and OBRA Level I Screening**

There is only one type of certified nursing facility, hospital Swing Bed, or certified boarding care facility admission that is exempt from both level of care determination and OBRA Level I Screening. This exemption is related to qualifying inter-facility transfers and applies regardless of payer source. These types of transfers are exempt because it is assumed that the appropriate PAS occurred at the time of the first facility admission. Facilities are responsible to ensure that documentation of previous OBRA Level I results are forwarded when an individual transfers to another facility. This applies even when an individual transfers to another facility after an acute hospital admission.

**Qualifying Inter-Facility Transfers**

1. Certified nursing facility, hospital Swing Bed, or certified boarding care facility to another certified nursing facility, hospital Swing Bed, or certified boarding care facility

   A PAS is not required if an individual is transferring from one certified nursing facility, hospital Swing Bed, or certified boarding care facility in Minnesota to another certified nursing facility, hospital Swing Bed, or certified boarding care facility in Minnesota.

2. Return to certified nursing facility, hospital Swing Bed, or certified boarding care facility after an acute hospital admission
A PAS is not required if an individual has been transferred from a certified nursing facility, hospital Swing Bed, or certified boarding care facility in Minnesota to an acute (not psychiatric) hospital and then back to the same or another certified nursing facility, hospital Swing Bed, or certified boarding care facility in Minnesota. This exemption applies only if the individual does not return to the community during these transfers.

A PAS may be considered valid for up to 60 days prior to admission. If an individual discharges to the community, but the PAS was completed within 60 days of the second admission, a new PAS would not be needed, even if the individual returned to the community.

Exemption from Level of Care Determination Only

In addition to the qualifying inter-facility transfers outlined above, certain individuals are not required to have level of care determinations completed by the Senior LinkAge Line® or PrimeWest Health before admission to a facility. These exemptions are outlined in MN Stat. sec. 256.975, subd. 7b. Unless previously completed, OBRA Level I screening for mental illness, developmental disability, or related conditions and OBRA Level II activity, if indicated, must still be completed for all individuals regardless of the exemptions described below.

1. Individuals Participating in Certain Home and Community Based Services (HCBS) Programs at the Time of Certified Nursing Facility, Hospital Swing Bed, or Certified Boarding Care Facility Admission

   Establishing the need for certified nursing facility, hospital Swing Bed, or certified boarding care facility level of care is part of the eligibility determination process for waiver programs funded under Medical Assistance (Medicaid) and for the State-funded Alternative Care (AC) program. This exemption from level of care determination applies to the Elderly Waiver (EW) and AC program for individuals age 65 or over and to individuals age 21 or over participating in Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), or the Brain Injury-Nursing Facility (BI-NF) programs. This does not apply to individuals who receive HCBS under the waiver for people with developmental disabilities (DD Waiver).

   - For individuals who are admitted to the certified nursing facility, hospital Swing Bed, or certified boarding care facility from the community and are being served by the HCBS programs identified above, OBRA Level I screening information completed during the face-to-face assessment is forwarded to the admitting certified nursing facility, hospital Swing Bed, or certified boarding care facility by the local agency. Documentation is updated to include verification that the individual continues to meet certified nursing facility, hospital Swing Bed, or certified boarding care facility level of care at the time of admission.

   - For individuals who are admitted to the certified nursing facility, hospital Swing Bed, or certified boarding care facility from a health care setting (hospital or clinic) and are being served by the HCBS programs identified above, an online PAS request should be submitted to www.mnaging.org. The request will be forwarded via secure email to the lead agency for completion of appropriate activities.
2. **Individuals who have been determined to have certified nursing facility, hospital Swing Bed, or certified boarding care facility services paid for indefinitely by the Veterans Administration (VA):** These individuals are exempt from PAS requirements related to level of care determinations, but must still have OBRA Level I screening completed since they are not exempt under Federal requirements for screening for mental illness, developmental disabilities, or related conditions. The PAS request must be completed online at [www.mnaging.org](http://www.mnaging.org).

**Preadmission Screening (PAS) and Medical Assistance (Medicaid) Reimbursement**

Medical Assistance (Medicaid) reimbursement for certified nursing facilities, hospital Swing Beds, or certified boarding care facilities 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 certified nursing facilities, hospital Swing Beds, or certified boarding care facilities shall not be provided for any member whom the local screener has determined does not meet the level of care criteria for certified nursing facilities, hospital Swing Beds, or certified boarding care facilities 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 certified nursing facility, hospital Swing Bed, or certified boarding care facility 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 certified nursing facility, hospital Swing Bed, or certified boarding care facility must include an un-reimbursed resident day in the certified nursing facility, hospital Swing Bed, or certified boarding care facility resident day totals reported to DHS.

**Emergency Admissions**

An emergency admission, as defined in [MN Stat. sec. 256.975, subd. 7b](https://www.revisor.mn.gov/statutes/text/256/975), to a certified nursing facility, hospital Swing Bed, or certified boarding care facility prior to screening is permitted when a person is admitted from the community to a certified nursing facility, hospital Swing Bed, or certified boarding care facility during Senior LinkAge Line® non-working hours when all of the following apply:

1. The physician has determined that delaying admission until the PAS 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 Senior LinkAge Line® must be contacted on the first working day following the emergency admission. However, PAS referrals can be made online 24 hours a day, including holidays. The Senior LinkAge Line® will retrieve the form on the next working day.

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. The admission date will be used as the screening date for qualified emergency admissions when the above criteria are met. If these criteria are not met, the date of the actual screening will be used.
PAS Statutory Timeline Summary

The information below provides a brief chart for use as a quick reference of tools and timelines for PAS activities.

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission from an acute hospital</td>
<td>Before admission for all admissions regardless of length of stay or payer source.</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>First business day after an admission that meets criteria as an emergency admission. An “emergency” admission is defined, in part, as occurring during non-working hours.</td>
</tr>
<tr>
<td>Admission from the community</td>
<td>Before admission for all admissions from the community. An online screening is only permitted when a health care professional (e.g., a physician or clinic nurse) is seeking admission and completes the online PAS referral with all required information.</td>
</tr>
<tr>
<td>NF Level of Care Waiver or Alternative Care program participants</td>
<td>PAS is not required to admit a person who has been receiving services in the community under EW, AC, CADI, BI-NF, or CAC waiver programs up to the date of admission and who continues to meet NF LOC. However, OBRA Level I must be completed for all people and forwarded to the admitting facility by the lead agency managing the HCBS services. OBRA Level II requirements must also be met for all admissions.</td>
</tr>
<tr>
<td>All people under age 65</td>
<td>Face-to-face visit within 40 working days of admission for people ages 21 – 64 if an online screening was used to admit.</td>
</tr>
<tr>
<td>All people with developmental disabilities</td>
<td>DHS must approve admission and length of stay.</td>
</tr>
<tr>
<td>All people under age 21</td>
<td>DHS must approve admission and length of stay before admission.</td>
</tr>
<tr>
<td>Admission from a Regional Treatment Center (RTC)</td>
<td>Before any admission from a Regional Treatment Center (RTC)</td>
</tr>
</tbody>
</table>

If a person received the PAS either online or through a face-to-face assessment, that PAS is valid for 60 calendar days. Sometimes, a person’s admission is delayed after the PAS is completed and documented in MMIS. If the screener determined NF level of care was needed, OBRA Level I was completed, and the screening document was entered, re-screening is not needed if the date of nursing facility admission occurs within 60 calendar days of the PAS. Nursing facilities may contact the Senior LinkAge Line® to receive a copy of the PAS. If the individual is on a home and community based waiver or alternative care, the nursing facility should contact the county to obtain a copy.

County Responsibility

PrimeWest Health serves as the entry point for all PAS referrals from the Senior LinkAge Line® for individuals enrolled in PrimeWest Senior Health Complete, MSC+, Prime Health Complete, and SNBC. PrimeWest Health has contracted completion of our PAS activities to our county partners. The Senior LinkAge Line® will coordinate with the counties directly for PrimeWest Health members. All PAS referrals must be completed online at www.mnaging.org.
1. If the county staff is unable to determine the need for nursing facility level of care or complete the OBRA Level I based on the information provided via online referral, a face-to-face assessment must be completed in order to determine the need for nursing facility level of care and complete OBRA Level I. The face-to-face assessment must be completed with 20 calendar days of the initial request for screening and prior to admission.

2. Face-to-face Long-Term Care Consultation (LTCC) visits are required for all individuals under age 65, regardless of program eligibility or participation, either before admission or within 40 days of admission if the person was admitted via online PAS screening.

3. In most circumstances, the county of location is responsible to provide assessment and support planning services. The county case manager is responsible for providing the assessment and support planning services to individuals age 65 and over and enrolled in PrimeWest Senior Health Complete or MSC+. County staff will coordinate to complete the screening and assessment activities, including coordination with other counties or local agencies when indicated.

4. DHS must approve all admissions for individuals under 21 years of age and individuals with developmental disabilities. The county staff will assure that the face-to-face requirement and exploration of community alternatives are explored and presented for individuals under 21 years of age. County staff will complete the required tasks for admission of an individual with a development disability.

5. County staff will forward a copy of the most recent OBRA Level 1 screening form to the facility when an individual participating in one of the HCBS programs listed is admitted to a certified nursing facility, hospital Swing Bed, or certified boarding care facility.

6. County staff are responsible for all OBRA Level I and II activities.

7. County staff will complete required entry into MMIS in the Long Term Care Screening Document subsystem to ensure payment to the certified nursing facility, hospital Swing Bed, or certified boarding care facility and document the person’s admission. Staff must enter this information into MMIS in a timely manner to verify that PAS requirements have been met.

**Certified Nursing Facility, Hospital Swing Bed, or Certified Boarding Care Facility Responsibility**

Certified nursing facilities’ responsibilities under the PAS program include the following:

1. Determining if the applicant has been screened
2. Informing applicants of PAS program requirements and background
3. Providing the screener with pertinent information obtained from the applicant or family
4. Providing all admitted individuals with information about assistance available to return to the community using DHS Brochure 2497, *Promoting and Supporting Independent Community Living*
5. Retaining records of the screening results, including PAS notice to resident that he/she has been screened, statement of applicant’s choice for placement, and copy of signed Level I documentation.
6. Forwarding screening results to the accepting facility when a patient is transferred

For further details on PAS, contact the Senior LinkAge Line® at 1-800-333-2433 (toll free) or a senior care coordinator at PrimeWest Health at 1-888-588-4420 (toll free).

**Covered Services**

PrimeWest Health covers room and board care for a PrimeWest Health member in a certified nursing facility 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 (OTC) 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 for PrimeWest Senior Health Complete members. 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 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 three-day qualifying hospital stay for members in PrimeWest Senior Health Complete or Prime Health Complete.

The nursing facility should notify PrimeWest Health when the resident enters a Medicare skilled level of care using the skilled nursing facility (SNF) notification form on [PrimeWest Health's provider web portal](https://www.primehealth.com/provider/). Effective January 1, 2018, the SNF notification form must be submitted electronically through the web portal. Paper copies of the SNF notification form will not be accepted.

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 members 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 nursing facility, as long as he/she meets the requirements of a skilled level of care.

PrimeWest Health follows Medicare skilled coverage criteria.

The Centers for Medicare & Medicaid Services (CMS) provides a list for consolidated billing items and services included in the per diem.

Ensure Medicare denials are issued in a timely manner.

Skilled nursing services are covered when necessary to maintain a member’s current condition or prevent or slow further deterioration so long as the member requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of a member’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the member’s current condition or to prevent or slow further deterioration is covered so long as the member requires skilled care for the safe and effective performance of the program.

**Skilled Nursing Facility (SNF) Notification Form for Prime Health Complete and PrimeWest Senior Health Complete**

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 submitted through the provider web portal. **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 a nursing facility. However, a resident may be responsible for some non-covered Medical Assistance (Medicaid) services, such as the following:
1. Special services
2. Other services not covered by Medical Assistance (Medicaid)
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 Medical Assistance (Medicaid) 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**

LTCFs 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 LTCF that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services.

**Leave Days (Skilled Nursing Facility [SNF]/Nursing Facility/Boarding Care Home [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 LTCF. A reserved bed must be held for a member on hospital leave or therapeutic leave. Payment for leave days in an SNF or nursing facility 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 LTCF 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 LTCF
3. The hospital leave days must be reported on the claim submitted by the LTCF with the appropriate hospital leave revenue code

**Therapeutic Leaves**
1. The member’s record must document the date and time the member leaves the LTCF 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 LTCF, hospital, or other entity eligible to receive Federal, State, or county funds for his/her maintenance
3. The therapeutic leave days must be reported on the claim submitted by the LTCF 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:
1. The occurrence of a health condition that is an emergency
2. 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
3. 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:
1. Members in an SNF, nursing facility, or certified BCF are entitled to 36 leave days per calendar year.
2. 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 LTCF 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 MN Stat. sec. 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:

<table>
<thead>
<tr>
<th>Leave</th>
<th>Return</th>
<th>Number of Leave Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30 p.m. Friday</td>
<td>11:30 a.m. Saturday</td>
<td>0 (Less than 23 hours)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>5:00 p.m. Saturday</td>
<td>1 (More than 23 hours)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>8:00 p.m. Sunday</td>
<td>2 (More than 23 hours; past midnight once)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>7:30 a.m. Monday</td>
<td>3 (More than 23 hours; past midnight twice)</td>
</tr>
</tbody>
</table>

### Occupancy Rate

Payment for hospital leave and therapeutic leave days are subject to the following occupancy rates:
1. LTCFs 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
2. LTCFs 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.)
3. The LTCF 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/nursing facility/BCH bed hold and leave day policy, call PrimeWest Health’s Provider Contact Center at 1-866-431-0802 (toll free).
Private (Single Bed) Rooms in Nursing Facilities

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 a nursing facility 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 Medical Assistance (Medicaid) 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
   a. Indicate the effective start date of the private room. If there is no date indicated, the signature date of the physician will be used as the start date for the authorization of the private room.
7. If member is age 65 or over, send the completed form by secure email to seniorcare@primewest.org or by fax to: 1-866-431-0804
8. If member is under age 65, send the completed form by secure email to seniorcare@primewest.org or by fax to: 1-866-431-0804
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 (Nursing Facilities/Swing Beds)

State law allows Medical Assistance (Medicaid) 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 Chapter 1, Requirements for Providers, 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 Medical Assistance (Medicaid) 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 Facility and Providers Compliance Division
   85 E 7th Place
   PO Box 64900
   Saint Paul, MN 55164
   Phone: 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
   PO Box 64973
   Saint Paul, MN 55164-0973

Exceptions: Swing Bed services may be billed by a hospital not enrolled in the Medical Assistance (Medicaid) 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 LTCF 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 prior to admittance to a Swing Bed in accordance with the policy described in the Preadmission Screening section of this chapter.
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 a nursing facility, 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 837I 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 Medical Assistance (Medicaid) nursing facilities’ per diem. This rate is computed annually, effective each July 1.
3. Only non-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. Bill type 210 is not required for PrimeWest Senior Health Complete or Prime Health complete members as PrimeWest Health pays both portions (Medicare and Medical Assistance [Medicaid]) of the claim. 
   a. The 60-day break in spell of illness is tracked in the PrimeWest Health web portal
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.

For nursing home residents who have exhausted their 180 days of managed Medical Assistance (Medicaid) days, the nursing facility provider must update the notification form using the PrimeWest Health web portal to notify PrimeWest Health of this change. PrimeWest Health will notify DHS.

Equalization

State law prohibits nursing 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 Additional Charges for Special Services section in this chapter.
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

Resident Trust Account

Administration of Resident Fund Accounts

An LTCF 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 LTCF 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 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 Medical Assistance (Medicaid) 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 LTCF
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 LTCF.

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

MN Stat. sec. 144.562 – Swing Bed Approval; Issuance of License Conditions
MN Stat. sec. 144.562, subd. 2 – Swing Bed Approval; Issuance of License Conditions: Eligibility for license condition
MN Stat. sec. 144.562, subd. 3 – Swing Bed Approval; Issuance of License Conditions: Approval of license condition
MN Stat. sec. 144A.161 – Nursing Home and Boarding Care Home Resident Relocation
MN Stat. sec. 256B.27, subd. 1 – Medical Assistance; Cost Reports: Reports and audits
MN Stat. sec. 256B.0625, subd. 2 – Covered Services: Skilled and intermediate nursing care
MN Stat. sec. 256B.0911 – Long-Term Care Consultation Services
MN Stat. sec. 256B.48 – Conditions for Participation:
MN Stat. sec. 256B.501, subd. 8 – Rates for Community-Based Services for Disabled: Payment for persons with special needs
MN Stat. sec. 256B.501, subd. 8a – Rates for Community-Based Services for Disabled: Payment for persons with special needs for crisis intervention services
MN Stat. sec. 256B.69, subd. 8 – Prepaid Health Plans: Preadmission screening waiver
MN Rules parts 9505.2390 – 9505.2500
MN Rules parts 9510.1020 – 9510.1140 – Special Needs Rate Exception for Very Dependent Persons with Special Needs
MN Rules part 9549.0060, subp. 11 – Determination of the Property Related Payment Rate: Capacity days
MN Rules part 9549.0070, subp. 3 – Computation of Total Payment Rate
Public Law 100-203: OBRA 1987 – Extension of Reductions under Sequester Order
Public Law 101-508: OBRA 1990 – Payments for Medical Costs
42 USC 1395 – Health Insurance for Aged and Disabled