Chapter 30

Long-Term Care (LTC)

Nursing Facility Liability:

- South Country Health Alliance does not have liability when the resident resides in the Nursing Facility at the time of enrollments.

- Persons enrolled in SeniorCare Complete (MSHO) and MSC+ have 180 days of nursing facility care liability for enrolled community members.

- Persons enrolled in Special Needs Basic Care (SNBC) – AbilityCare, SingleCare, and SharedCare have 100 days of nursing facility care liability for enrolled community members.

- Continued nursing facility care beyond the benefit is covered by Minnesota Department of Human Services.

- The three-day qualifying hospital stay is waived for members enrolled in the two Medicare Advantage Special Needs Plans SeniorCare Complete (MSHO) and AbilityCare (SNBC).

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 properly care for themselves

Demand Bill: A claim sent to Medicare that the resident's family or other interested party requests to receive a decision from Medicare regarding the status of a claim.

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/DD; must admit and care for those MA recipients certified as requiring the same level of care as the bed certification.

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

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

Reserved Bed: The same bed that a 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 MN Statutes 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

Skilled nursing facilities (SNF), nursing facilities (NF), or boarding care homes (BCH), licensed as Nursing Facility providers by the Minnesota Department of Health (MDH. Swing bed hospital provider eligibility information is specified in the Swing Bed section of this section.

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 or ICF 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 Members

Nursing facilities provide services to individuals who have been screened and determined to need a nursing facility level of care.

South Country Health Alliance eligible members must reside in a certified bed that matches his/her certified level of care.

South Country Health Alliance will cover the cost of care for a member who resides in a certified nursing facility or certified BCH if all of the following requirements are met:

Certified nursing facility and Certified BCF:

- The care is ordered by a physician
- The nursing facility is in compliance with state and federal regulations.
- The care provided in a nursing facility or BCH is required as determined through the preadmission screening process completed by the county prior to admission to the facility.

Swing Bed Hospital:

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

Physician Certification

A physician must certify the need for a certified nursing facility or certified boarding care facility. The Physician Certification (edocs DHS 1503) form must be completed in the following instances:

- Upon initial admission or upon readmission following discharge
- When a member transfers from one nursing facility to another
- When a member transfers within a facility from one level of care to another
- When a member returns from an unauthorized leave exceeding 24 hours
- When a member 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 Physician Certification form.

The Physician Certification (edocs DHS 1503) form must be completed by the following:

- **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 Physician Certification form or the actual admission date, whichever is later.

Physician Visits for Nursing Facility and Boarding Care Recipients

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 recipient 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 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 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 nursing facilities) and the facility holds the bed for the resident. The medical record must indicate the resident was absent from the facility and, upon return, must be updated with any changes. A transfer does not prohibit a facility from thinning the medical record.

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

Resident Classification

The case mix system utilized for Minnesota nursing facilities (NFs) certified for Medicaid (MA or Medical Assistance) 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 nursing facilities.

The following resident assessments must be conducted by the facility in accordance with the most current CMS guidelines, and are used in determining a resident's case mix classification for reimbursement purposes.

- Admission assessment
- Annual assessment
- Significant change assessment
- Quarterly assessments
- Significant correction to prior Comprehensive Assessment.
- Significant correction to prior Quarterly Assessment.

Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). The 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 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 is accurate. Audits conducted by the MDH may result in changes to the resident's case mix classification and therefore the per diem rate. The nursing facility or the resident may request a reconsideration of the case mix classification from MDH. Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency).

For more information on Minnesota case-mix for nursing facilities, follow this link to the MDH website:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/

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 (NA) Registry

Nursing Assistant Training and Competency Evaluation

A nursing 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
- Has successfully completed an approved training and competency evaluation program or a competency evaluation program approved by the state
- Has been deemed or determined competent as provided by the MDH

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

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

A nursing 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
- 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 nursing 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
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
651-431-2282
DHS.LTCpolicycenter@state.mn.us

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

Minnesota Statutes and Federal law require that all applicants to certified 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 developmental disabilities.

Preadmission Screening for Mental Illness or Developmental Disabilities

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, developmental disability, or a related condition must receive a preadmission screening 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 developmental disability 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 developmental disability (and subsequent referrals for more completed evaluation as needed) are limited to the following:

- 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 all of the following are met:
    - The person is entering a certified nursing facility directly from an acute care hospital after receiving acute inpatient care at the hospital.
    - The person requires nursing facility services for the same condition for which he or she received care in the hospital.
    - The attending physician has certified before admission that the individual is likely to receive less than 30 days of nursing facility services.

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

Preadmission Screening (PAS) for Nursing Facility 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 developmental disability 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, subd. 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.

An individual admitted to a certified nursing facility for a short-term stay that, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for 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.

Preadmission Screening (PAS) and Medical Assistance Reimbursement

Medical Assistance reimbursement for a nursing facility shall be authorized for a South Country Health Alliance member only if a preadmission screening has been conducted prior to admission or an exception has been authorized. South Country Health Alliance reimbursement for a nursing facility shall not be provided for any member whom 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 member with mental illness is approved by the local mental health authority or an admission for a member with developmental disability or related condition is approved by the State developmental disability authority.

The nursing facility shall not bill a person who is not a South Country Health Alliance member 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 the Minnesota Department of Human Services (DHS).

Emergency Admissions

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

Emergency admission to 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 non-working hours and:

- The physician has determined that delaying admission until the preadmission screening is completed would adversely affect the person's health and safety
- 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
- The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended

South Country Health Alliance and/or the local agency 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 summarizes timelines and other requirements for the LTCC as well as some follow-up activity performed by county LTCC staff.

Preadmission Screening		
TIMELINES FOR PAS & ASSESSMENTS FOR NURSING FACILITY ADMISSIONS		
	Under 65	**Over 65**
Hospital Discharge: nursing facility admission meets criteria for a 30-day Exemption	No PAS required	No PAS required
Inter-facility Transfer (NF-NF or NF-Acute 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

Acute Hospital discharge to nursing facility: 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 40 working days of admission.	Before admission: telephone or face-to-face
Admission from an acute hospital to nursing facility on non-working county day	Next working day after admission LTCC visit within 40 working days of admission if telephone screen	Next working day after admission
Initial screening after emergency nursing facility admission	Next working day after admission LTCC visit within 40 working days of admission if telephone screen	Next working day after admission
Age 18-20 years	Face-to-face LTCC and approval required for any admission to nursing facility	--
Required face-to-face assessment for people age 21 – 64 admitted to nursing facility if admitted by telephone screening	Within 40 working days of admission	--

- Under certain circumstances, Managed Care Organizations (MCOs) 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 nursing facility must notify all applicants who request admission, and their families, that a PAS is required before admission. The nursing facility must also notify the county PAS screener of all new applicants

- Under most circumstances, the MCO 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 MCO in which the prison is enrolled

- If the person is being discharged from the hospital to the nursing facility, contact the MCO in which the person is enrolled.

Nursing facility and Boarding Care Home Responsibility

Nursing Facilities and boarding care facilities' responsibilities under the preadmission screening program include the following:

- Determining if applicant has been screened
- Informing applicants of preadmission screening program requirements and background
- Obtaining consent for preadmission screening and notifying the local county agency.
- Providing the screener with pertinent information obtained from the applicant or family

For further details on preadmission screening, contact South Country Health Alliance.

The nursing facility should retain the following documents:

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

Covered Services

South Country Health Alliance covers room and board care for a South Country Health Alliance member in a certified nursing facility or certified boarding care facility. 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.)
- 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):

South Country Health Alliance 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 the following:

- Special services
- Other services not covered by Medical Assistance
- 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 South Country Health Alliance members 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
- 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)

180-Day Benefit – SeniorCare Complete (MSHO) and MSC+

South Country Health Alliance is responsible for a total of 180 days of nursing home room and board for SeniorCare Complete (MSHO) and MSC+ members. After the initial 180 days, billing for nursing home care should be submitted to DHS.

If a South Country Health Alliance member is residing in a nursing home at the time he/she enrolls in South Country Health Alliance SeniorCare Complete (MSHO), he/she is **not** entitled to the 180-day benefit.

100-Day Benefit – Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare

South Country Health Alliance is responsible for a total of 100 days of nursing home room and board for Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare members. After the initial 100 days, billing for nursing home care should be submitted to DHS.

If a South Country Health Alliance member is residing in a nursing home at the time he/she enrolls in South Country Health Alliance Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare he/she is **not** entitled to the 100-day benefit.

180-Day Separation Period

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

After the member is in the community for 180 days, South Country Health Alliance would be responsible for a new, distinct 180-day nursing facility benefit period for a SeniorCare Complete (MSHO)/ MSC+ member or a new, distinct 100-day nursing facility benefit for an Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare member who is still community based.

If the member becomes institutionalized prior to the end of the 180-day separation period, no new nursing facility benefit period applies to South Country members.

100 Medicare Skilled Nursing Days

South Country Health Alliance SeniorCare Complete (MSHO) and AbilityCare (SNBC) SNP members are entitled to up to 100 days of Medicare coverage if the Medicare qualifications have been met.

The nursing facility should notify South Country Health Alliance when the resident enters a Medicare skilled level of care using the Nursing Home Communication Form (DHS-4461) Form #2297.

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

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. South Country Health Alliance follows Medicare skilled coverage criteria.

Notification and Prior Authorization for Custodial and Skilled Stays

Nursing facilities are required to contact SCHA/MMSI Health Services (approval authority) of member admissions within one business day of the admission, whenever possible.

- Skilled care (SNF) requires an ***authorization*** from SCHA/ MMSI Health Services within one business day of admission or determination, and when ongoing services are extended beyond the current authorization.

- Non-skilled (NF) care requires notification to SCHA/ MMSI Health Services within one business day of admission or re-determination.

For skilled SNF admission:

- Please fax to MMSI 1-888-889-7822 within 24 hrs of admission a completed copy of Nursing Home Communication Form (DHS-4461) Form which includes the reason that skilled care is needed. This could be:
    - Copy of the physician order
    - Hospital discharge note, in appropriate
    - Explanation from staff of why the skilled level of care is needed. You can document this information in the "Notes" section on the form.

The admission information will be reviewed and MMSI will fax our decision back to the nursing home with the date that concurrent review is needed.

For skilled SNF concurrent review:

- Please fax to MMSI 1-888-889-7822 on the date that concurrent review is due the Nursing Home Communication Form (DHS-4461) Form with clinical documentation supporting the continued need for skilled care. Clinical documentation could include: nurse's notes explaining daily skilled nursing care and/or therapy plan of care and notes. Documentation should explain course of treatment, show progress and reasons that continued care is needed.

MMSI Health Services will review the request and contact the nursing facility with a determination within 10 days.

- If an approval is issued, please inform the member or responsible party when initial service and or/ additional days are approved.
- If a denial is issued, a Notice of Medicare Non-Coverage (NOMNC) must be issued and given to the member within 2 days prior to discharge or end of skilled

need. Please send a signed copy of the NOMNC to MMSI Health Services along with the Nursing Home Communication Form (DHS-4461) Form.

- Members will be covered through the service end date as identified on the Notice of Medicare Non-Coverage (NOMNC) form.
  - i.e. Service end date on the NOMNC is January 14th > member received the NOMNC on January 12th > Skilled (SNF) coverage will be paid through January 14th.

South Country Health Alliance does NOT require a prior three (3) day hospitalization for skilled (SNF) care coverage for members. Nursing facilities must assure that members have available Medicare Part A days, meet SNF coverage/eligibility criteria, and must meet one of the following:

- Present to a clinic, Emergency Department or Urgent Care setting and require ongoing skilled care, observation, monitoring, or rehabilitation therapy that cannot be appropriately provided in the home setting.
- The member is a long-term care resident, and experiencing an acute illness or exacerbation of a chronic condition that would meet criteria for an inpatient admission, and care can be safely be provided in the nursing facility. Coverage will only be authorized for the period of time that the member requires skilled services that meet coverage criteria.

Intensive Service Days

Nursing facilities have the option to bill for Intensive Service Days to avoid the hospital stay.

Prior authorization is required for all Intensive Service Day stays. Nursing facilities must complete the Nursing Home Communication Form (DHS-4461) form and fax it to SCHA/ MMSI at 1-888-889-7822.

MMSI Health Services will contact the Nursing Facility to determine appropriateness and authorize the stay. Revenue code 0230 must be used to code the ISD stay.

Rehabilitative Services

Nursing 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 facilities per diem. South Country Health Alliance will not make separate reimbursement for therapy services for

residents of a nursing facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative 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 SeniorCare Complete (MSHO)/AbilityCare (SNBC) requires the nursing facility to do the billing for SeniorCare Complete (MSHO)/AbilityCare (SNBC) covered rehabilitative services for dually eligible members, you must follow the programs requirements until SeniorCare Complete (MSHO)/AbilityCare (SNBC) benefits are exhausted.

Leave Days (nursing facility/nursing facility/boarding care facility)

Leave days are eligible for payment. A leave day must be for hospital leave or therapeutic leave of a member who has not been discharged from a nursing facility. A reserved bed must be held for a member on hospital leave or therapeutic leave. Payment for leave days in a skilled nursing facility or nursing facility is limited to 30% of the applicable payment rate.

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

Hospital leaves:

- The member must have been transferred from a nursing facility to the hospital
- The member's record must document the date the member was transferred to the hospital and the date the member returned to the nursing facility
- The hospital leave days must be reported on the claim submitted by the nursing facility with the appropriate hospital leave revenue code

Therapeutic leaves:

- The member's record must document the date and time the member leaves the nursing facility and the date and time of return
- 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 nursing facility, hospital, or other entity eligible to receive Federal, State, or county funds for his/her maintenance
- The therapeutic leave days must be reported on the claim submitted by the nursing 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 one of the following:

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

Payment for therapeutic leave days is limited to the number of days listed below:

- Members in a nursing facility or skilled nursing facility or certified BCF are entitled to 36 leave days per calendar year.

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 nursing facility to hold the bed beyond the 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. Residents who exhaust their hospital leave days and are subsequently discharged from the facility are entitled to be readmitted to the facility to the next available bed.

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

For SeniorCare Complete (MSHO) and AbilityCare (SNBC) members, leave of absence days are shown on the bill with revenue code 018X and leave of absence days as units. However, charges for leave of absence days are shown as zero on the bill, and the nursing facility cannot bill the beneficiary for them. Occurrence span code 74 is used to report the leave of absence from and through dates. The electronic data elements are shown in the following chart. Refer to the Medicare Claims Processing manual, Chapter 25, "Completing and Processing the UB-04 (CMS 1450) Data Set," for further information about billing, including UB-04 data elements and the corresponding fields in electronic billing records.

The following data elements are required for reporting leave of absences:

- Revenue code 018X
- Revenue code units and charges
- Occurrence Span Code 74 and associated dates
- Patient Status Code

Note: When the patient does not return from a leave of absence, regardless of the reason, the nursing facility must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the nursing facility must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A member cannot be an inpatient in two institutions at the same time.) This closes the open admission the patient's utilization record.

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:

- Nursing facilities with 25 or more licensed beds will not receive payment if the average occupancy rate was less than 96 percent during the month of leave
- Nursing 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.)
- Nursing 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
- Divide by the number of licensed beds to determine the occupancy rate for the month.

Private (Single Bed) Rooms in Nursing Facilities

To receive payment for a single bedroom the following requirements must be met:

- 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)
- 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
- The bed in the single bed room must be certified for MA by MDH
- The facility must estimate the length of time the private room is needed
- The Quality Assessment and Assurance Committee (QAAC) must recommend the single bed room and document the member's condition necessitating the single bed room
- The attending physician's statement, the QAAC's statement, and any additional relevant documentation from the member's medical record, must be submitted to South Country Health Alliance for review, using either the Nursing Home Communication Form (DHS-4461) form.

Nursing Facilities would fax the completed form to SCHA/MMSIF at 1-888-889-7822

Swing Bed Hospital Services (nursing facility/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 member 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 preadmission screening prior to placement as specified in the *Preadmission Screening* section of this chapter

- Nursing Home Communication Form (DHS-4461) form must be submitted SCHA/MMIS by faxing to 1-888-889-7822

Eligible Providers

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.
- Sign a Swing Bed Provider Agreement with DHS.

Eligible Members

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

Preadmission Screening (PAS)

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

- Persons admitted from the community on a physician certified emergency basis or people admitted on a county non-working day must be screened on the first county working day after admission;
- 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
- 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 a South Country Health Alliance member is limited to 40 days. 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 South Country Health Alliance. 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 837I format using the facility's National Provider Identifier (NPI). 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) South Country Health Alliance 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 SeniorCare Complete (MSHO)/AbilityCare (SNBC) eligible members must be billed to South Country Health Alliance. If the services are not covered by Medicare, South Country Health Alliance may be billed under the member's Medicaid benefit.
- If members receive their Medicare benefits from either Original Medicare or another Medicare Advantage program, the ancillary services must be billed to the other Medicare plan. If the services are not covered by Medicare, South Country Health Alliance may be billed under the member's Medicaid benefit with a copy of Medicare's denied EOB.

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.

Exceptions

- The Equalization Law does not apply to third party payers
- 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 nursing 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 programs (contact the LTC Policy Center at 1-651-431-2282 for more information). If discharge of residents is necessary, discharge planning and relocation must be done in accordance with all provision 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 a nursing facility may result in the segregation of Medical Assistance 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 nursing facility to promptly report any organizational or ownership changes to the MDH to maintain enrollment with South Country Health Alliance. MDH will determine if the nursing facility continues to meet minimal State and Federal standards under new ownership.

If South Country Health Alliance receives notification that an entity has changed ownership, South Country Health Alliance will follow up with the provider to see if the provider wants to continue to be part of the South Country Health Alliance network. If

the provider does, South Country Health Alliance will send them the appropriate documents to reflect the change. Once South Country Health Alliance has received the appropriate documents, it will inactivate the old “owner” and make a new entry in PMA with the new/updated information with the effective date of the change.

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

Legal References

MS 144.562, subd.2 & 3 - Swing Bed Approval
MS 256B.27, sub.1 - Medical Assistance; Cost Reports
MS 256B.0625, subd.2 - Covered Services
MS 256B.0911, - Long-Term Care Consultation Services
Minnesota Rules 9505.0410 to 9505.0420, - TC; Rehabilitative and Therapeutic Services
Minnesota Rules 9549.0010 to 9549.0080, - Nursing Facility Payment Rates
MS 256B.48, - Conditions for Participation
MS 256B.501, - Rates for Community-Based Services for Disabled
Minnesota Rules 9549.0060, subp.11 - Determination of the Property Related Payment Rate
Minnesota Rules 9549.0070, subp.3 - Computation of Total Payment Rate