

# Nursing Facility

## Chapter 30

### Nursing facility liability

- South Country Health Alliance does not have liability when the recipient /patient reside in the Nursing Facility at the time of enrollment.
- Recipient/patients enrolled in SeniorCare Complete and MSC+ has 180 days of nursing facility care liability for all enrolled community members.
- Recipient/patients enrolled in AbilityCare (SNBC) have 100 days of nursing facility care liability for enrolled community members.
- Continued nursing facility care beyond the benefit is covered by MN DHS.
- The three day hospital stay is waived for recipients enrolled in 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 care for themselves properly

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

**Facility with Distinct Part Certification:** Sections of the facility certified as psychiatric, NF, or ICF/MR; must admit and care for those Medical Assistance 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/MR.

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

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

**Short-term Stay:** Nursing Facility admission expected to be less than 14 days.

**Swing Bed:** A hospital bed that has been granted a license under MN Statutes 144.562 and which has been certified to participate in the federal Medicare program under US code title 42, section 1395.

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

## **Eligible Providers**

Psychiatric hospitals, skilled nursing facilities (SNF), nursing facilities (NF), or boarding care homes (BCH), certified by Minnesota Department of Health (MDH) are eligible to provide LTC services.

Facilities with distinct part certification must admit and care only for those Medical Assistance recipients certified as requiring the same level of care as the bed certification.

Exemptions: A 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 payment for the cost of recipient care.

## **Eligible Recipients**

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

MSC+, SeniorCare Complete (MSHO), and AbilityCare (SNBC) eligible recipients must reside in a certified bed that matches his or her certified level of care.

South Country Health Alliance (SCHA) will cover the cost of care for a recipient who resides in a certified NF or certified BCH, if the following requirements are met:

### **Certified Nursing and Certified Boarding Care Facility**

- The care is ordered by a physician
- The care is provided in compliance with MDH

- The care provided in an NF or BCH is required because of physical or mental limitations determined through the preadmission screening process completed by the county, prior to admission to the facility, with certain exceptions defined below:
  - Swing Bed
  - Utilization Control

### **Preadmission Screening (PAS) Under State and Federal Statutes**

NF stays longer than 30 days are required to have the PAS completed.

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 preadmission screening 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 cost associated with unnecessary certificated nursing facility admissions. The purpose of the screening activity is to determine the need for nursing facility level of care, and to complete activities required under federal law related to mental illness and mental retardation.

### **Covered Services**

SCHA covers room and board care for MSC+, SeniorCare Complete (MSHO), and AbilityCare (SNBC) recipients in a certified NF 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):

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

- Special services
- Other services not covered by SCHA
- Spenddown amounts

#### Additional Charges for Special Services

State law allows a facility to charge residents for the 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 SCHA 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 the report of 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).

#### **Notification of admission**

NF is required to notify SCHA of admissions and changes by completing the Nursing Home Communication form and faxing to SCHA/MMSI. Fax number 888-889-7822

NF has the responsibility to give the recipient/patient the NOMNC letter at end of the skilled stay.

#### **Intensive Service Days (ISD)**

NF's have the option to bill for ISD to avoid the hospital stay.

Prior authorization is required for all ISD stays. NF must complete the Nursing Home Communication form and fax to MMSI. Fax number 888-889-7822

MMSI Health Services will contact the facility to determine appropriateness and authorize the stay.

Revenue code 0230 must be used to code the ISD stay.

Nursing Home Communication Form is located on the Forms tab of our web site.

### **Private Room coverage**

Services must be medically necessary and prior approved by SCHA/MMSI. . NF must complete the Nursing Home Communication form and fax to MMSI. Fax number 888-889-7822

### **Rehabilitative Services**

Long Term care facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service rehabilitative 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. SCHA will not make separate reimbursement for therapy services for residents of the long term care facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services.

The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patients records that fully disclose the extent of the benefits provided. Also, if Medicare requires the LTC facility to do the billing for Medicare covered rehabilitative services for dually eligible recipients, you must follow Medicare's requirement until Medicare benefits are exhausted (Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy must be billed by the SNF even when another entity renders the services under an arrangement with the SNF.).

### **Leave Days (SNF/NF/BCH)**

Leave days are eligible for SCHA payment. A leave day must be for hospital leave or therapeutic leave of a recipient who has not been discharged from a long term care facility. A reserved bed must be held for a recipient on hospital leave or

therapeutic leave. Payment for leave days in an SNF or NF is limited to 60% of the applicable payment rate.

#### Hospital Leaves

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

#### Therapeutic Leaves

- The recipient's record must document the date and time the recipient leaves the long term care facility and the date and time of return.
- The recipient may go on a home visit or vacation, to a camp that meets MDH licensure requirements, or to another residential setting except another long term care 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 long term care facility with the appropriate therapeutic leave revenue code.

#### **Leave Day (leave of absence) 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 mean one of the following:

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

SCHA payment for Therapeutic Leave Days is limited to the number of days listed below:

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

SCHA 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 long term care facility to hold the bed beyond the MA benefit.

AbilityCare and Senior Care Complete - Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for leave of absence days are shown as zero on the bill, and the SNF 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:

Where the patient does not return from a leave of absence, regardless of the reason, the SNF 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 SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on 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.

### **Private (Single Bed) Rooms in NFs**

To receive SCHA payment for Medicaid covered services for a single bedroom the following requirements must be met:

- The recipient's attending physician must determine and certify that a single bed room is necessary because of a medical or behavioral condition that affects the health of the recipient or other residents (the estimated length of time the private room is needed must also be indicated)
- The single bed room must be located in an nursing facility which has chosen to assign a greater proportion of their costs to single bed rooms
- The bed in the single bed room must be certified for Medical Assistance with MDH
- The Quality Assessment and Assurance Committee (QAAC) must review the attending physician's recommendation for the single bed room, and sign a statement that a single bed room is required
- The attending physician's statement, the QAAC's statement and any additional relevant documentation from the recipient's medical record, must be submitted to SCHA/MMSI for review.

### **Swing Bed Hospital Services (NF/Swing Beds)**

State law allows Medical Assistance/Medicare payments for swing bed services provided by 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 Medical Assistance/Medicare patient requires skilled nursing care per Medicaid/Medicare 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 section.

### **Eligible Provider (Hospital Swing Bed)**

To be eligible as a swing bed provider in Medical Assistance/Medicare program a provider must accomplish the following:

- Received Medicare certification as a Medicare swing bed provider
- Sign a Swing Bed Provider Agreement with DHS Limitations

In accordance with state law, payment for swing bed services for a Medical Assistance/Medicare recipient is limited to 40 days, unless the Commissioner of MDH grants an extension. Approval for services in excess of 40 days must be requested in writing from MDH at least ten days before the end of the maximum 40-day stay. The extension approval must be attached to claims, which includes service dates beyond the initial 40-day period. Eligible hospitals are allowed a total of 1,460 days of swing bed use per the state's fiscal year (July 1 to June 30) provided that no more than 10 hospital beds are used as swing beds at any one time.

### **Ancillary Services**

Routine care and services, similar to those provided in a Nursing Facility, are included in the daily swing bed payment rate. All other covered services may be billed to the MA program. All ancillary services must be billed in accordance with the respective guidelines.