

Nursing Facilities

Revised: [October 28, 2024](#)

- [Overview](#)
- [Eligible Providers](#)
- [Eligible Members](#)
 - [Physician Certification](#)
 - [Physician Visits for NF and Board and Care Members](#)
 - [Preadmission Screening \(PAS\) under State and Federal Laws](#)
- [Covered Services](#)
 - [Leave Days \(SNF/NF/BCH\)](#)
 - [Leave Day Limitations](#)
 - [Private \(Single Bed\) Rooms in NFs](#)
- [Noncovered Services](#)
 - [Additional Charges for Special Services](#)
 - [Discharge and Transfer](#)
- [Medicare and Other Insurance](#)
 - [Exceptions for Prepaid Health Plans](#)
 - [Spendedown Refund Requests](#)
 - [Prohibited Practices](#)
- [Billing](#)
 - [Resident Classification System](#)
 - [Billing for Custodial Care](#)
 - [Billing for Rehabilitative Services](#)
 - [Billing for Swing Bed Services](#)
 - [Information on Nurse Aide Reimbursement](#)
 - [Nursing Assistant Registry](#)
 - [Administration of Resident Trust Account Funds](#)
 - [Cost Reporting](#)
- [Definitions](#)
- [Legal References](#)

Overview

The Minnesota Department of Human Services (DHS) is responsible for developing and interpreting policy and the administration of Medicaid programs impacting Minnesota nursing facilities and board and care homes that are enrolled with Minnesota Health Care Programs (MHCP). DHS also develops and implements rates and policies regarding nursing facility services, quality of care and transitions to and from a nursing facility. DHS focuses on the quality of care and services provided to MHCP members living in nursing facilities, and provides information and resources related to nursing facilities and nursing facility care.

Eligible Providers

To be eligible to provide services for Long Term Care, providers must meet the requirements and submit the forms listed on the [Nursing Facility Enrollment Criteria and Forms](#) provider enrollment page. Enrolled skilled nursing facilities (SNF), nursing facilities (NF) or board and care homes (BCH) licensed as nursing facility providers by MDH are eligible to provide services and bill for MHCP. See the [Swing Bed Hospital Services \(Nursing Facility Swing Beds\)](#) section of the Provider Manual for information about eligibility requirements for swing bed providers.

Eligible Members

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

MA eligible members must reside in a Medicaid certified bed in order for their stay to be considered for payment by MHCP. For more long term care eligibility requirements, refer to your county financial worker.

MHCP covers the cost of care for a member who resides in a certified NF or certified BCH if the certified NF or certified BCH meets the following requirements:

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

Physician Certification

A physician must certify the need for a certified NF or certified board and care facility. Providers must complete the [Physician Certification \(DHS-1503\) \(PDF\)](#) form in the following instances:

- Upon initial admission or upon readmission following discharge
- When a member transfers from one nursing facility to another

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 \(DHS-1503\) \(PDF\)](#).

The staff at the facility must complete the Physician Certification form within 30 days before 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 NF and Board and Care Members

Under state rule, a member must have a current admission medical history and complete physical examination performed and recorded by a physician, physician assistant or nurse practitioner within five days before or within seven days after admission. After the admitting examination, the physician must see the member at least every 30 days for the first 90 days after admission and then every 60 days, or sooner when medically necessary. A physician visit is considered timely if it occurs within 10 days after the date the visit was required.

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

Members 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 members at least every six months and board and care home members at least once per year. Each refusal must be documented in the member's medical record and signed by the member and the physician.

Preadmission Screening (PAS) under State and Federal Laws

Federal and state laws require preadmission screening (PAS) for all people prior to entering a Medical Assistance-certified nursing facility, certified board and care facility or hospital swing bed. In Minnesota, the PAS is submitted to the Senior Linkage Line and includes both nursing facility level of

care determination and screening people for developmental disabilities or mental illness, referred to as OBRA Level I screening. In addition, nursing facility members on MA must have their level of care established at admission and 90 days after admission. Refer to the [Minnesota Senior Linkage Line](#) for the state's PAS policies and related procedures.

Preadmission Screening for Mental Illness or Developmental Disability

An OBRA Level II evaluation is needed when a person is suspected to have or has a confirmed diagnosis of a serious mental illness or a developmental disability or related condition and is seeking admission to a nursing facility. The lead agency must complete the OBRA Level II prior to nursing facility admission.

Questions regarding OBRA Level II or resident reviews for Developmental Disabilities:

- [Community-Based Services Manual](#)
- [DHS Form 4248: OBRA Level II evaluative report for people with developmental disabilities or related conditions](#)
- OBRA Level II DD: dsd.obra@state.mn.us

Questions regarding OBRA Level II or resident reviews for Mental Illness (MI):

- [DHS Bulletin #21-25-02](#)
- [DHS Form 3457: OBRA Level II Evaluative Report Form for people with mental illness](#)
- [Pre-admission Screening and Resident Review \(PASRR Level II-MI\)](#)
- OBRA Level II MI: dhs.mh.pasrr@state.mn.us

Nursing Facility and Board and Care Home Responsibility

NFs and certified Board and Care facilities' responsibilities under the PAS program include the following:

- Ensure [preadmission screening](#) has been completed prior to admission and have a copy of final results.
- Re-establish NF level of care for people classified as PA1 or PA2 on the relevant MDS quarterly assessment by submitting a Level of Care Redetermination referral to the Minnesota Senior LinkAge Line within three days of receiving the PA1 or PA2 classification.

For further details on PAS, contact the Minnesota Senior LinkAge Line at 800-333-2433.

Covered Services

MHCP covers room and board care for an MA member 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 (for example, January services cannot be billed until February 1).

Items and 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 (such as aspirin, acetaminophen, antacids, cough syrups, and so forth)

Leave Days (SNF/NF/BCH)

Leave days are eligible for MHCP 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 an SNF or NF is limited to 30 percent of the applicable payment rate.

To be eligible for MHCP payment, the following criteria must apply for each leave type:

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 hospital leave revenue code 0185.

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 the member's care.
- The therapeutic leave days must be reported on the claim submitted by the nursing facility with the therapeutic leave revenue code 0183.

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.

Number of 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
- The 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: MHCP considers a reserved bed as 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

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 which 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

MHCP payment for therapeutic leave days is limited to 36 leave days per calendar year for members in an SNF or NF or certified boarding care facility.

MHCP payment for leave days beyond the 18 or 36-day limit is prohibited, regardless of the occupancy rate. However, the member or family may opt to pay the nursing facility to hold the bed beyond the MHCP benefit period, if the facility offers this special service. If a member is on leave day status, under most circumstances the facility may not discharge the member or fill the bed with another resident until after the 18 or 36-day leave period has elapsed, and not at all if the member has elected to self-pay for days beyond the 18 or 36-day leave period. MA members that exhaust their hospital leave days and are subsequently discharged from the facility are entitled to be readmitted to the facility to the next available bed.

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

For questions on SNF, NF or BCH bed hold and leave day policy, contact:

Long-Term Care Policy Center
DHS.LTCpolicycenter@state.mn.us

Private (Single Bed) Rooms in NFs

To receive MHCP payment for a single bedroom for a MA member, NFs must meet the following requirements:

- The single bed room must be located in a NF which has chosen to assign a greater proportion of their costs to single bed rooms.
- The bed in the single bed room must be certified for MA by MDH.
- 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 facility must estimate the length of time the private room is needed
- The facility's Quality Assessment and Assurance Committee (QAAC) must recommend the single bed room and document the member's condition necessitating the single bed room

Complete [Private Room Request \(DHS-8164\) \(PDF\)](#) and fax to:

Department of Human Services
Nursing Facilities Rates and Policy – Private Room Request
Fax: 651-431-7466

Noncovered Services

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

MHCP covers the majority of costs incurred while in a nursing facility. However, a member may be responsible for some noncovered MHCP services, such as:

- Special services
- Other services not covered by MHCP
- 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 members in all areas of the facility and charged separately at the same rate for the same services. To qualify as a special service, the following conditions must be satisfied for MA and private-pay members:

- 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 or 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)

Direct questions about nursing facility services to:

Long-Term Care Policy Center

DHS.LTCpolicycenter@state.mn.us

Discharge and Transfer

When a member is discharged, they are terminated from a residential treatment period of care through the formal release or death of the member. 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 member returns to the facility, all admission record requirements must be completed to be eligible for Medical Assistance payment.

When a member is transferred, they are temporarily placed into an inpatient hospital (not including regional treatment centers or other nursing facilities) and the facility holds the bed for the member. The medical record must indicate the member was absent from the facility and upon return must be updated with any changes.

In addition, any transfer, discharge or relocation of members must comply with all applicable federal or state laws, including the state Resident Relocation law.

Medicare and Other Insurance

Medicare and other insurance is considered primary to Medical Assistance. If the member is receiving a Medicare benefit or other Third Party Liability insurance (TPL), that information must be entered on the header level of the Coordination of Benefits screen when submitting Room and Board claims.

Refer to the [Medicare and Other Insurance](#) portion of the Provider Basics section under [Billing Policy Overview](#).

Exceptions for Prepaid Health Plans

For nursing home members who have both MA and a Prepaid Medical Assistance Program (PMAP), and have exhausted their 180 days of managed Medicaid days, the nursing facility provider must fax

the [Nursing Facility \(NF\) Communication Form \(DHS-4461\) \(PDF\)](#) to a member's managed care plan to notify the plan of this change. The managed care plan will fax the Nursing Facility Communication Form to DHS at 651-431-7548 and send copies to the nursing facility. The state Equalization Law prohibits nursing facilities from charging private-pay residents higher rates than those approved by DHS for MA members. The law also allows residents to be awarded three times the payments that result from a violation. For more information on Equalization and Special Services, refer to the section on this page on [Additional Charges for Special Services](#).

Exceptions to the Equalization Law:

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

Spendedown Refund Requests

Members residing in a nursing facility who have an LTC spenddown are obligated to pay the nursing facility their LTC spenddown amount.

When a member is also covered by Medicare Part A, the member may receive a refund for a portion of the LTC spenddown amount due to Medicare payments the nursing facility receives after the member has already paid the LTC spenddown. The nursing facility may retain the refund amount for payment of a past due obligation but only with the agreement of the member. Follow the [Instructions for spenddown refund request for Long-term Care \(DHS-4277A\) \(PDF\)](#) to apply for a spenddown refund.

Prohibited Practices

Certain practices, including, but not limited to the following are considered prohibited practices and violations could result in penalties to the provider:

- financial exploitation
- restricting resident choice of vendors of medical services
- differential treatment
- discrimination
- kickbacks
- refusing admission to the nursing facility

Refer to [Minnesota Statutes, 256R.04](#) for more details.

Billing

Resident Classification System

Case Mix rates paid by MHCP to approved providers are determined by the Minnesota Department of Health. For information on how the case mix system works, refer to the [Minnesota Case Mix Review Program](#). For information on the Short Stay Rate (DDF), Penalty Rate (AAA), other case mix related questions and contact information, refer to [Case Mix Information for Providers](#).

Billing for Custodial Care

Do not bill for the care and monthly room and board services (per diem) until the beginning of the following month (for example, January services cannot be billed until February 1).

Bill as follows:

- Bill room and board services in the 837I format using the facility's NPI.
 - Use the 21x bill type.

- Use 019X for the revenue code.
- Enter appropriate occurrence codes, occurrence span codes and value codes.
- Include TPL and Medicare on the COB screen when applicable.
- Do not bill for day of discharge or day of death.
- The daily room and board payment rate for custodial services is set by the case mix rate determined by the Minnesota Department of Health.
- Bill ancillary services for Medicare eligible people to Medicare. If the services are not covered by Medicare, MHCP may be billed (fee-for-service members only).

Review the [MN-ITS User Manual for LTC Services](#) for instructions on completing a LTC claim.

Billing for Rehabilitative Services

Nursing facilities may provide rehabilitative services to members 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. The party designated to do the billing will bill for all rehabilitative services. Refer to [Rehabilitative Services](#) for covered services.

Billing for Swing Bed Services

See [Swing Bed Hospital Services \(Nursing Facility Swing Beds\)](#).

Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact:

Long-Term Care Policy Center

DHS.LTCpolicycenter@state.mn.us

Nursing Assistant Registry

The [Minnesota Nursing Assistant Registry](#) lists nursing assistants who have met Minnesota training and testing standards to work in nursing homes and certified board and care homes. The registry also has information about nursing assistants who have substantiated findings of abuse, neglect and theft.

Nursing assistants, employers and others can search the registry at the [Minnesota Nursing Assistant Registry Search \(state.mn.us\)](#) website. You can search by entering a first name, last name and date of birth or the nursing assistant's certificate number.

Administration of Resident Trust Account Funds

A nursing facility member may deposit his or her funds, including the personal needs allowance established under Minnesota statutes, in a resident trust account fund administered by the facility. A nursing facility must comply with MDH regulations concerning resident funds in addition to the following provisions:

- Credit to the account all funds attributable to the account including interest and other forms of income
- Not co-mingle resident trust account funds with the funds of the facility
- Keep a written record of the member's resident trust account fund, including the date, amount and source of deposit or withdrawal recorded within five working days of the account activity
- Require a member 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 member's account. Receipts for the actual item purchased for the member's use may substitute for a receipt signed by the member
- Not charge the member a fee for administering the member's account
- Not solicit donations or borrow from a resident trust account fund

- Report and document to the county a member's donation of money to the facility when the donation equals or exceeds the statewide average MHCP payment for SNF care
- Not use resident trust account funds as collateral for or payment of any obligations of the facility
- Treat funds remaining in a member's account upon death or discharge as required by MDH regulations

Limitations on Use of Resident Trust Account Funds

Do not use funds in the member's resident trust account fund to purchase the following items or services generally reported in the facility's cost report:

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

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

Direct questions on LTC policy and services to:

Long-Term Care Policy Center
 Department of Human Services
 P.O. Box 64973
 St. Paul, MN 55164-0973
DHS.LTCpolicycenter@state.mn.us

Cost Reporting

Nursing facilities in Minnesota must file a cost report with DHS by Feb. 1 of each year. A facility's cost report covers the previous reporting year, which runs from Oct. 1 to Sept. 30. DHS uses these cost reports to calculate a facility's rate for the following rate year. The rate year runs from Jan. 1 to Dec. 31. This can be accessed in the [Nursing Facility Provider Portal](#).

Definitions

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

Demand bill: A claim sent to Medicare that the member'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 members certified as requiring the same level of care as the bed certification.

LTC facility: A residential facility certified by 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 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 the member 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 [Minnesota Statutes, 144.562](#) and which has been certified to participate in the federal Medicare program under 42 U.S.C. section 1395. See the [Swing Bed Hospital Services \(Nursing Facility Swing Beds\)](#) section of the Provider Manual.

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

Legal References

[Minnesota Statutes, 256B.27](#), subdivision 1 (Medical Assistance; Cost Reports)

[Minnesota Statutes, 256B.0625](#), subdivision 2 (Covered Services; Skilled and intermediate nursing care)

[Minnesota Statutes, 256B.0911](#) (Long-Term Care Consultation Services)

[Minnesota Statutes, 256B.48](#) (Conditions for Participation)

[Minnesota Statutes, 256B.501](#) (Rates for Community-Based Services for Disabled)

[Minnesota Statutes, 256R.42](#) (Rate Adjustment for the First 30 Days)

[Minnesota Statutes, 256R.04](#) (Prohibited Practices)

[Minnesota Statutes, 144A.161](#) (Nursing Home and Boarding Care Home Resident Relocation)

[Minnesota Rules, 9505.0410 to 9505.0420](#) (Long-Term Care Facilities; Rehabilitative and Therapeutic Services)

[Minnesota Rules, 9549.0010 to 9549.0080](#) (Nursing facility payment rates)

[Minnesota Rules, 9549.0060](#), subpart 11 (Determination of the Property-Related Payment Rate; Capacity days)

[Minnesota Rules, 4658.0710](#), subpart 4 (Physician visits)

[Code of Federal Regulations, 483.30\(c\)](#) (Physician services; Frequency of physician visits)