

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 57	Date: NOVEMBER 8, 2006
	Change Request 4220

NOTE: Transmittal 54, dated September 15, 2006 is rescinded and replaced with Transmittal 57, dated November 8, 2006. Based on contractor comments, section 20.1, fourth paragraph, of the manual instruction has been revised to clarify the policy regarding the type of hospital in which a qualifying stay may take place for purposes of SNF coverage. All other information remains the same. This correction cancels CR 5406.

Subject: Clarification/Update to Chapter 8, Pub. 100-02

I. SUMMARY OF CHANGES: Clarification of longstanding SNF coverage policy is made in the following areas: respiratory therapy; daily skilled services; the administrative level of care presumption; and, the 3 day qualifying hospital stay requirement. We have also updated the overview of the Medicare SNF PPS.

Clarification

Effective Date: July 27, 1966

Implementation Date: December 14, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	8/Table of Contents
R	8/10/Requirements - General
R	8/10/10.1/Medicare SNF PPS Overview
R	8/20/20.1/Three-Day Prior Hospitalization
R	8/30/30.1/Administrative Level of Care Presumption
R	8/30/30.6/Daily Skilled Services Defined
R	8/50/50.8/50.8.2/Respiratory Therapy

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-02	Transmittal: 57	Date: November 8, 2006	Change Request 4220
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NOTE: Transmittal 54, dated September 15, 2006 is rescinded and replaced with Transmittal 57, dated November 8, 2006. Based on contractor comments, section 20.1, fourth paragraph, of the manual instruction has been revised to clarify the policy regarding the type of hospital in which a qualifying stay may take place for purposes of SNF coverage. All other information remains the same. This correction cancels CR 5406.

SUBJECT: Clarification/Update to Chapter 8, Pub. 100-02

I. GENERAL INFORMATION

A. Background: Section 1861(i) of the Act requires that a beneficiary be an inpatient of a hospital for not less than 3 consecutive days before discharge from the hospital in order to be eligible for coverage of post-hospital extended care services. To be eligible, a beneficiary must also require a skilled level of care as set forth in 42 CFR Part 409, Subpart D. The basic requirements set forth in 42 CFR 409.30 provide that a beneficiary in a SNF is considered to meet the level of care requirements of §409.31 up to and including the assessment reference date for the 5-day assessment prescribed in §413.343(b), when correctly assigned to one of the Resource Utilization Groups (RUGs) that is designated in the annual publication of the Federal Prospective Payment Rates for SNFs as representing the required level of care.

Section 4432(b)(5)(D) of the Balanced Budget Act (BBA) 1997 amended section 1861(h)(7) of the Act to cover the full range of services that SNFs generally provide, either directly or under arrangements with any qualified outside source, including respiratory therapy.

B. Policy:

CMS is clarifying in the manual our longstanding policies with respect to the 3-day hospital stay, the presumption of coverage, and the provision of respiratory therapy in a SNF:

1. Section 1861(i) of the Act requires that a beneficiary be an inpatient of a hospital for not less than 3 consecutive days before discharge from the hospital in order to be eligible for coverage of post-hospital extended care services. Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as inpatient status commences with the calendar day of hospital admission. See 31 Fed. Reg. 10116, 10118-19 (July 27, 1966).
2. A beneficiary who is correctly assigned into one the RUGs that is designated in the annual publication of the Federal prospective rates as representing the required level of care, is presumed to meet the SNF level of care requirement up to and including the assessment reference date on the 5-day assessment prescribed in 42 CFR 413.343(b).
3. Respiratory Therapy can now be provided directly, or under an arrangement, regardless of whether or not the therapist is employed by the SNF's transfer agreement hospital. Prior to the change set forth in

the BBA, respiratory therapy could only be covered under Part A if provided directly by the professional nursing staff employed by the nursing home or through an agreement with a transfer hospital.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4220.1	Contractors shall be in compliance with the instructions in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 8, Sections 10, 20, 30, 30.6 and 50.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	None									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: July 27, 1966, the date of the regulation setting forth CMS longstanding interpretation of what constitutes an inpatient admission.</p> <p>Implementation Date: December 14, 2006</p> <p>Pre-Implementation Contact(s): Julie Stankivic (410) 786-5725</p> <p>Post-Implementation Contact(s): Julie Stankivic (410) 786-5725</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
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Medicare Benefit Policy Manual

Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Table of Contents

(Rev. 57, 11-08-06)

30.1 - Administrative *Level of Care* Presumption

10 - Requirements - General

(Rev.57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

The term “extended care services” means the following items and services furnished to an inpatient of a skilled nursing facility (SNF) either directly or under arrangements as noted in the list below:

- Nursing care provided by or under the supervision of a registered professional nurse;
- Bed and board in connection with furnishing of such nursing care;
- Physical or occupational therapy and/or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;
- Medical social services;
- Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;
- Medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (see §50.7) under an approved teaching program of the hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect, and
- Other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements.

Post-hospital extended care services furnished to inpatients of a SNF or a swing bed hospital are covered under the hospital insurance program. The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. *Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as a person who appears at a hospital's emergency room seeking examination or treatment or is placed on observation has not been admitted to the hospital as an inpatient; instead, the person receives outpatient services. For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission. See 31 Fed. Reg. 10116, 10118-19 (July 27, 1966).*

The beneficiary must *also* have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §20.2.2 applies. *In addition, the beneficiary must require SNF care* for a condition that was treated during the qualifying

hospital stay, or for a condition that arose while in the *SNF* for treatment of a condition for which the beneficiary was previously treated in *the* hospital.

Extended care *services* include SNF care for beneficiaries involuntarily disenrolling from *Medicare Advantage* plans as a result of *a Medicare Advantage* plan termination when they do not have a 3-day hospital stay before SNF admission, *if admitted to the SNF before the effective date of disenrollment.*

10.1 - Medicare SNF PPS Overview

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Section 1888(e) of the *Social Security* Act provides the basis for the establishment of the per diem Federal payment rates applied under *the* PPS to SNFs that received their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNFs that first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based. *See Chapter 28, Section 2836, of the Provider Reimbursement Manual, Part I, (Pub. 15-1) for a comprehensive discussion of the SNF PPS.*

20.1 - Three-Day Prior Hospitalization

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

The hospital discharge must have occurred on or after the first day of the month in which the individual attained age 65 or, effective July 1, 1973, became entitled to health insurance benefits under the disability or chronic renal disease provisions of the law. The 3 consecutive calendar day *stay* requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as a person who appears at a hospital's emergency room seeking examination or treatment or is placed on observation has not been admitted to the hospital as an inpatient; instead, the person receives outpatient services. For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission. See 31 Fed. Reg. 10116, 10118-19 (July 27, 1966).

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In addition, the qualifying hospital stay must have been medically necessary. Medical necessity will generally be presumed to exist. When the facts *that* come to the *intermediary's attention during the course of its* normal claims review process indicate that the hospitalization may not have been medically necessary, it will fully develop the case, checking with the attending physician and the hospital, as appropriate. The intermediary will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice.

The 3-day hospital stay need not be in a hospital with which the SNF has a transfer agreement. However, the hospital must be *either a Medicare* participating hospital or an institution *that* meets at least the conditions of participation for an emergency services hospital (*see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 5, §20.2, for definition of an emergency services hospital*). A nonparticipating psychiatric hospital need not meet the special requirements applicable to psychiatric hospitals. Stays in Religious Nonmedical Health Care Institutions (See Pub 100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 5, §40, for definition of RNHCIs) are excluded for the purpose of satisfying the 3-day period of hospitalization.

NOTE: While a 3-day stay in a psychiatric hospital satisfies the prior hospital stay requirement, institutions *that* primarily provide psychiatric treatment cannot participate in the program as SNFs. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating SNF is likely to receive only

non-covered care. In the SNF, the term “non-covered care” refers to any level of care which is less intensive than the SNF level of care which is covered under the program. (See §§30*ff.*).

30.1 – Administrative *Level of Care* Presumption

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Under *the* SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (*ARD*) for the 5-day assessment prescribed in 42 CFR 413.343(b), when *correctly* assigned to one of the Resource Utilization Groups (RUGs) that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. *If the beneficiary is not admitted (or readmitted) directly to a SNF after a qualifying hospital stay, the administrative level of care presumption does not apply.*

For purposes of this presumption, the assessment reference date is defined in accordance with 42 CFR 483.315(d), and must occur no later than the eighth day of posthospital SNF care. *Consequently, if the ARD for the 5-day assessment* prescribed in 42 CFR 413.343(b) is set on day 9, or later, the administrative level of care presumption does not apply.* The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the facts of the beneficiary's condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

To be correctly assigned, the data coded on the Resident Assessment Instrument (RAI) must be accurate and meet the definitions described in the Long Term Care Facility RAI User's Manual. The beneficiary must receive services in the SNF that are reasonable and necessary. Services provided to the beneficiary during the hospital stay are reviewed to ensure proper coding of the most recent version of the RAI. The two examples illustrated below demonstrate a correct assignment and an incorrect assignment.

Incorrect Assignment: *IV med provided in hospital coded on MDS, but IV was for a surgical procedure only – as a consequence, the MDS is not accurate and the presumption does not apply (see Chapter 3, Section P of the RAI).*

Correct Assignment: *Beneficiary is receiving oxygen therapy as well as rehab service. The respiratory therapy services are found reasonable and necessary; however, the rehab services are found not reasonable and necessary, resulting in a revised RUG. Beneficiary was and is now correctly assigned – presumption applies.*

A beneficiary who groups into other than one of the *RUGs* designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

**Includes Medicare Readmission/Return Assessment.*

The following scenarios further clarify that a beneficiary's correct classification to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care triggers the coverage presumption under the initial 5-day, Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge.

1. Routine SNF Admission Directly From Qualifying Hospital Stay

If the beneficiary is admitted to the SNF immediately following a 3-day qualifying hospital stay, there is a presumption that he or she meets the Medicare level of care criteria when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the 8th day of the stay.

2. Admission to SNF does not immediately follow discharge from the qualifying hospital stay, but occurs within 30 days (as required under the "30 day transfer" rule)

If the beneficiary is discharged from the hospital to a setting other than the SNF, the presumption of coverage does not apply, even if the beneficiary's SNF admission occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in the file.

3. SNF Resident is Re-Hospitalized and Then Returns Directly to the SNF

If a beneficiary who has been in a covered Part A stay requires readmission to a hospital, and subsequently returns directly to the SNF for continuing care, there is a presumption that he or she meets the level of care criteria upon readmission to the SNF when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of that assessment, which must occur no later than the eighth day of the stay.

4. Routine SNF Admission Directly From Qualifying Hospital Stay, but Initial Portion of SNF Stay Covered by Another Insurer (Medicare as Secondary Payer)

When a beneficiary goes directly from a qualifying hospital stay to the SNF, but the initial portion of the SNF stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the primary insurer ends. Accordingly, the Medicare required schedule of assessments is not required to begin until the first day of Medicare coverage. If a beneficiary met the level of care criteria for Medicare coverage during the first 8 days of the stay following a qualifying hospital stay, and the other insurer covered this part of the stay, there is no presumption. If Medicare

becomes primary before the eighth day of the stay following a qualifying hospital stay, the presumption would apply through the assessment reference date on the 5-day assessment or, if earlier, the eighth day of the stay.

5. Readmission to SNF Within 30 Days After Discharge From Initial SNF Stay – No Intervening Hospitalization

As noted in scenario 1, if a beneficiary is initially admitted to the SNF directly from the hospital for a covered Part A stay, the presumption for that stay is applicable when the beneficiary is correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second SNF admission. (If the beneficiary is transferred to a hospital, and returns directly to the SNF, see scenario 3 above).

6. Initial, Non-Medicare SNF Stay Followed by Qualifying Hospitalization and Readmission to SNF for Medicare Stay

Dually eligible (Medicare/Medicaid) beneficiaries whose initial stay in the SNF is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the SNF following a qualifying hospitalization, when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. (Of course, in order to qualify for Medicare coverage upon readmission, the beneficiary must be placed in the portion of the institution that is actually certified by Medicare as a SNF.)

No presumption of coverage applies when Medicare is the secondary payer for days 1 through 8 of the covered stay where Medicare becomes primary after day 8 due to a reversal or denial by the secondary insurer.

7. Transfer From One SNF to Another

There is no presumption of coverage in cases involving the transfer of a beneficiary from one SNF to another or from SNF-level care in a swing bed to a SNF. The presumption only applies to the SNF stay that immediately follows the qualifying hospital stay when the beneficiary is correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. Therefore, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption only applies if the beneficiary was receiving acute care (rather than SNF-level care) immediately prior to discharge from the swing-bed hospital.

Federal Register Notices Designating RUGs Representing Required Level of Care

30.6 - Daily Skilled Services Defined

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis,” i.e., on essentially a 7 days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE:

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively *affect* his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient’s skilled status is based on a restorative program, medical evidence must exist to justify the services. In most instances, it is expected that *a skilled restorative program will be, at most, only a few weeks in duration.*)

50.8.2 - Respiratory Therapy

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

See *Pub. 100-02*, Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services,” §100.

Prior to BBA 1997, respiratory therapy *could* be provided *by a SNF either* under an arrangement with a hospital *with which the SNF had a transfer agreement or through the SNF’s nursing staff. Section 4432(b)(5)(D) of the BBA amended section 1861(h)(7) of the Act to cover the full range of services that SNFs generally provide, either directly or under arrangements with any qualified outside source. As a result, the services of respiratory therapists are now covered under Part A when provided under arrangements made directly between the SNF and any qualified respiratory therapist, regardless of whether the therapist is employed by the SNF’s transfer agreement hospital.*