CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	Centers for Medicare & Medicaid Services (CMS)
Transmittal 120	**Date: November 2, 2018**
	Change Request 11004

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

EFFECTIVE DATE: December 4, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 4, 2018

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/ 40.1/ Who May Sign the Certification or Recertification for Extended Care Services
R	5/ 10.2/ Admission of Medicare Patients for Care and Treatment

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-01	Transmittal: 120	Date: November 2, 2018	Change Request: 11004

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I. GENERAL INFORMATION

A. Background: This CR updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. There are no policy changes.

Pub 100-01, Chapter 4, §40.1:

This section is revised by adding appropriate cross-references.

Pub 100-01, Chapter 5, §10.2:

This section is revised by adding an appropriate cross-reference.

B. Policy: These changes are intended to clarify the existing content; there are no policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11004 - 01.1	Contractors and impacted providers shall be aware of the updates to Pub 100-01, Chapters 4 and 5.	X	X							Hospital, Providers, SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11004 - 01.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Anthony Hodge, Anthony.Hodge@cms.hhs.gov , Bill Ullman, 410-786-5667 or william.ullman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare General Information, Eligibility, and Entitlement

Chapter 4 - Physician Certification and Recertification of Services

40.1 -Who May Sign the Certification or Recertification for Extended Care Services

(Rev.120, Issued: 11-02-18, Effective: 12- 04-18, Implementation: 12- 04-18)

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician. See Pub. 100-02, Medicare Benefit Policy Manual *at* chapter 8, §40.1, for a discussion of "direct" and "indirect" employment relationships in this context*, and at chapter 15, §190.C (for physician assistants), §200.D (for nurse practitioners), and §210.D (for clinical nurse specialists), regarding the required collaboration between the physician and the physician extender*.

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in Chapter 5, §70 of this manual.

Medicare General Information, Eligibility, and Entitlement

Chapter 5 - Definitions

10.2 - Admission of Medicare Patients for Care and Treatment

(Rev.120, Issued: 11-02-18, Effective: 12- 04-18, Implementation: 12- 04-18

The participation of a provider of services, which voluntarily files an agreement to participate in the health insurance program, contemplates that such provider will admit Medicare beneficiaries for care and treatment, and upon admission, will provide them with such services as are ordinarily furnished by the provider to its patients generally.

A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by CMS as a basis for termination of the agreement for cause (see the regulations at 42 CFR 489.53(a)(2)*, and also see Pub. 100-04, Medicare Claims Processing Manual, chapter 1, §30.1.3*).