CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 242	**Date: March 16, 2018**
	Change Request 10512

Transmittal 242, dated March 16, 2018, as part of a companion package is being re-issued to correct a typo in all the revision lines to correctly spell the word "Implementation" in Pub. 100-01, Transmittal 114 and in addition, to correct a spacing issue in Pub. 100-02 Transmittal 242, to create a spacing line between the heading for section 70.4 and the paragraph that follows. Transmittal number, date issued and all other information remains the same.

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

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: June 19, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 19, 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	8/ 20.2.3/ Readmission to a SNF
R	8/ 30.1/ Administrative Level of Care Presumption
R	8/ 40.1/ Who May Sign the Certification or Recertification for Extended Care Services
R	8/ 50.3/ Physical Therapy, Speech-Language Pathology, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision
R	8/ 50.8.2/ Respiratory Therapy
R	8/ 70.4/ Services Furnished Under Arrangements With Providers

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. 100-02	Transmittal: 242	Date: March 16, 2018	Change Request: 10512

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

EFFECTIVE DATE: June 19, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 19, 2018

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. No policy, processing, or system changes are anticipated.

Pub 100-02, Chapter 8, §20.2.3:

This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

Pub 100-02, Chapter 8, §30.1:

This section is revised by modifying the language so that it no longer pertains to only one particular type of case-mix model, and by adding a reference to the posting of the CMS-designated case-mix classifiers on the SNF PPS web site. These changes reflect similar revisions made in the corresponding regulations at 42 CFR 409.30 and 413.345 by the FY 2018 SNF PPS final rule (82 FR 35644-45, August 4, 2017).

Pub 100-02, Chapter 8, §40.1:

This section is revised by updating the existing citation to the regulations at 42 CFR 483.40(e), in order to reflect their redesignation at 42 CFR 483.30(e) in the long-term care facility requirements reform final rule (81 FR 68829, October 4, 2016).

Pub 100-02, Chapter 8, §50.3:

This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2:

This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4:

The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.

B. Policy: These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

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	
10512 - 02.1	Contractors and impacted providers shall be aware of the updates to Pub 100-02, Chapter 8.	X	X							Hospital, Providers, SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10512 - 02.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	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):
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.

ATTACHMENTS: 0

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

20.2.3 - Readmission to a SNF

(Rev.242, Issued: 03-16-18, Effective: 06-19-18; Implementation: 06-19-18)

If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days *after the day of discharge*, the 30-day transfer requirement is considered to be met. The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days *after the first day of noncoverage*. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage. (See §§20.2.2 and 20.2.2.3 above for situations where a period of more than 30 days between SNF discharge and readmission, or more than 30 days of noncovered care in a SNF, is followed by later covered care.)

30.1 – Administrative Level of Care Presumption

(Rev.242, Issued: 03-16-18, Effective: 06-19-18; Implementation: 06-19-18)

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 one of the *case-mix classifiers that CMS designates for this purpose* as representing the required level of care. *The current set of case-mix classifier designations appears in the paragraph entitled "Case Mix Adjustment" on the SNF PPS web site, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.* 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 *case-mix classification*. Beneficiary was and is now correctly assigned – presumption applies.

A beneficiary who *is not assigned* one of the *case-mix classifiers* 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 *assignment of* one of the *case-mix classifiers that CMS designates for this purpose* as representing the required level of care *would serve to* trigger 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 one of the *case-mix classifiers that CMS designates for this purpose* 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 eighth 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 one of the *case-mix classifiers that CMS designates for this purpose* 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 one of the *case-mix classifiers that CMS designates for this purpose* 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 one of the *case-mix classifiers that CMS designates for this purpose* 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 one of the *case-mix classifiers that CMS designates for this purpose* 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.

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

(Rev.242, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

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 (NP), a clinical nurse specialist (CNS) or, effective with items and services furnished on or after January 1, 2011, a physician assistant (PA)) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

In this context, the definition of a “direct employment relationship” is set forth in the regulations at 20 CFR 404.1005, 404.1007, and 404.1009. Under the regulations at 42 CFR 424.20(e)(2)(ii), when a physician extender has a direct employment relationship with an entity other than the facility, and the employing entity has an agreement with the facility that includes the provision of general nursing services under the regulations at 42 CFR 409.21, an “indirect employment relationship” exists between the physician extender and the facility. By contrast, such an indirect employment relationship does not exist if the agreement between the facility and the physician extender’s employer solely involves the performance of delegated physician tasks under the regulations at 42 CFR *483.30(e)*.

Further information regarding certification and recertification of extended care services, including details on the content of the certification or recertification, timing of recertifications and the impact of delays on certifications and recertifications, appears in Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, “Physician Certification and Recertification of Services,” §§40 - 40.4.6.

50.3 - Physical Therapy, Speech-Language Pathology, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision

(Rev.242, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

Physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services must be provided by the SNF or by others under arrangements with the SNF for beneficiaries in either a covered Part A stay or a non-covered stay in the SNF *(see Pub. 100-04, Medicare Claims Processing Manual, Chapter 6, §20.5, for a more detailed discussion of therapy services under consolidated billing, the SNF "bundling" requirement)*. Bundling *of therapy services* to the SNF is not required for beneficiaries residing in a non-certified portion of *the same institution that also includes* a *participating* distinct part SNF. See Chapter 7, SNF Part B Billing, §10 in the Medicare Claims Processing Manual, for a clarification of bill types used to make this distinction clear in billing. *For a discussion of skilled therapy (that is, PT, SLP, and OT) services in the context of the SNF level of care criteria, see §§30.4ff. of this chapter.*

50.8.2 - Respiratory Therapy

(Rev.242, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

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 *(see the regulations at 42 CFR 409.27(b))*.

70.4 - Services Furnished Under Arrangements With Providers

(Rev.242, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

The SNF may arrange with others to furnish covered *services such as* physical therapy, occupational therapy, or speech-language pathology services. The SNF (rather than an outside provider/supplier, another SNF or a HHA) bills Medicare, and payment is made directly to the SNF. When such arrangements are made, SNF receipt of payment for the arranged services (as with services provided directly) relieves the beneficiary or any other person of further liability to pay for them. *See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, section 10.3, for a general discussion of services furnished "under arrangements."*

The specific details of the ensuing payment arrangement between the SNF and the outside supplier (such as the actual payment amount and timeframe) represent a private, "marketplace" transaction that is negotiated between the parties themselves and falls outside the purview of CMS; however, in order for the arrangement itself to be valid, the SNF must, in fact, make payment to its supplier for services rendered. See Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 10.4ff. for additional information on arrangements between SNFs and their suppliers.