CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 261	**Date: October 4, 2019**
	Change Request 11454

SUBJECT: Manual Updates for CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

I. SUMMARY OF CHANGES: This Change Request (CR) provides manual updates for SNF PDPM.

EFFECTIVE DATE: November 5, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 5, 2019
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	3/10 - Benefit Period (Spell of Illness)
R	3/20 - Inpatient Benefit Days
R	8/10.1 - Medicare SNF PPS Overview
R	8/20.1 - Three-Day Prior Hospitalization
R	8/20.1.1 - Three-Day Prior Hospitalization - Foreign Hospital
R	8/30.1 – Administrative Level of Care Presumption
R	8/30.7 - Services Provided on an Inpatient Basis as a “Practical Matter”
R	8/30.7.1 - The Availability of Alternative Facilities or Services
R	8/30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case
R	8/40.1 - Who May Sign the Certification or Recertification for Extended Care Services
R	8/70.4 - Services Furnished Under Arrangements

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: 261	Date: October 4, 2019	Change Request: 11454

SUBJECT: Manual Updates for CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

EFFECTIVE DATE: November 5, 2019
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IMPLEMENTATION DATE: November 5, 2019

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to manualize CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM).

B. Policy: These changes have been implemented with CR11152 with an October effective date.

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	
11454 - 02.1	Contractors shall be aware of the manual updates in Chapters 3 and 8 of the Medicare Benefit Policy Manual (100-02).	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Valeri Ritter, 410-786-8652 or valeri.ritter@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 3 - Duration of Covered Inpatient Services

10 - Benefit Period (Spell of Illness)
(Rev.261, Issued_10-04-19, Effective: 11-05-19, Implementation: 11-05-19)
A3-3035, HO-215

A "Benefit period" is a period of consecutive days during which medical benefits for covered services, with certain specified maximum limitations, are available to the beneficiary. Under Part A, 60 full days of hospitalization plus 30 coinsurance days represent the maximum benefit period. The *benefit* period is renewed when the beneficiary has not been *an inpatient of* a hospital or *of a* SNF *(see §20.B)* for 60 *consecutive* days. Refer to Pub.100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, "Deductible, Coinsurance Amounts, and Payment Limitations" for additional information on benefit periods.

20 - Inpatient Benefit Days
(Rev.261, Issued_10-04-19, Effective: 11-05-19, Implementation: 11-05-19)
A3-3103, A3-3135, HO-216, SNF-242

A. Inpatient Hospital Benefit Days

A patient having hospital insurance coverage is entitled, subject to the inpatient deductible and coinsurance requirements, to have payment made on his/her behalf for up to 90 days of covered inpatient hospital services in each benefit period. Also, the patient has a lifetime reserve of 60 additional days (see Chapter 5, §10).

B. Posthospital Extended Care Days

A patient having hospital insurance coverage is entitled (subject to the coinsurance requirements described in detail in Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, "Deductibles, Coinsurance Amounts, and Payment Limitations") to have payment made on his/her behalf for up to 100 days of covered inpatient extended care services in each benefit period.

Refer to Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter *3, §10.4.4* for the definition of SNF inpatient for benefit period purposes.

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

10.1 - Medicare SNF PPS Overview
(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

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 *Balanced Budget Act (*BBA*) of 1997* sets forth the formula for establishing the rates as well as the data on which they are based. See also Pub. 15-1, Provider Reimbursement Manual, Part I, chapter 28, section 2836 for background information on the SNF PPS; Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 30ff. for SNF PPS billing instructions; and Pub. 100-08, Medicare Program Integrity Manual, chapter 6, sections 6.1ff. regarding medical review of SNF PPS claims.

20.1 - Three-Day Prior Hospitalization
(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

In accordance with section 226(c)(1)(B) of the Social Security Act and the implementing regulations at 42 CFR 409.30(a)(2), 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 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 this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

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 A/B MACs (A) 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 A/B MAC will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice. However, in accordance with Pub. 100-04, Medicare Claims Processing Manual, chapter 30, section 130.2.A, when a beneficiary qualifies for limitation *on* liability in connection with the hospital stay (or a portion thereof), this conclusively establishes that the hospital stay (or portion thereof) was not medically necessary.

Even if a beneficiary's care during a qualifying hospital stay becomes less intensive during the latter part of the stay, the date of hospital "discharge" in this context is still considered to be the day that the beneficiary physically leaves the hospital, and the level of care being furnished at that particular point is not a determining factor as long as some portion of the stay included at least 3 consecutive days of medically necessary inpatient hospital services. In addition, when a hospital inpatient's care needs drop from acute- to SNF-level but no SNF bed is available, the regulations at 42 CFR 424.13(c) permit a physician to certify that the beneficiary's continued inpatient stay in the hospital is, in fact, medically necessary under this particular set of circumstances (see also Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 10.6). Accordingly, such additional, "alternate placement" days spent in the hospital can be included in the 3-day count toward meeting the SNF benefit's qualifying hospital stay requirement.

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 Manual, Chapter 5, §20.2, for the 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 Manual, Chapter 5, §40, for definition of RNHCIs) are excluded for the purpose of satisfying the 3-day period of hospitalization. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 40.1.5, regarding a qualifying stay that consists of "general inpatient care" furnished in a hospital under the hospice benefit.

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 setting, the term "non-covered care" refers to any level of care less intensive than the SNF level of care that is covered under the program. (See §§30ff.).

20.1.1 - Three-Day Prior Hospitalization - Foreign Hospital

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

Regardless of whether a foreign hospital stay is itself coverable under the heading of "foreign hospital services" (see Pub. 100-04, Medicare Claims Processing Manual, chapter 32, §§350ff. for a description of the foreign hospital services that are payable by Medicare), an inpatient stay of 3 or more days in a hospital outside the United States may *nevertheless* satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States *as long as* the foreign hospital *can qualify* as an "emergency hospital" (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, §20.2, for the definition of an emergency services hospital). If a stay of 3 or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the SNF will submit documentation to the A/B MAC (A). This evidence will be either:

A. An itemized bill or hospital form prepared by the foreign hospital showing dates of admission and discharge and a description of the illness or injury treated (obtained from the beneficiary); or

B. A medical report prepared by the foreign hospital and sent to the patient's U.S. physician showing dates of admission and discharge and a description of the illness or injury treated (obtained from the physician).

If neither type of evidence can be obtained, the SNF will secure whatever information is available for submission to the A/B MAC (A). When the A/B MAC (A) receives a bill involving a prior inpatient stay in a foreign hospital, it contacts the regional office for a determination as to whether the prior stay requirement

is met. If the regional office states the hospital does not qualify as an "emergency hospital," the A/B MAC (A) advises the provider that the prior inpatient stay requirement is not met.

If the regional office states the hospital qualifies as an "emergency hospital" and documentation is submitted as outlined in either §§20.2.1 or 20.2.2 which otherwise meets the prior-stay requirement, the A/B MAC (A) processes the SNF claim.

30.1 – Administrative Level of Care Presumption

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

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 *initial Medicare* 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. *While this assessment is commonly referred to as the "5-day" assessment (reflecting its original 5-day assessment window), an additional 3 grace days have always been available beyond that window for actually setting the ARD; further, as of October 1, 2019, those additional 3 grace days are directly incorporated into the assessment window itself, thus resulting in an overall 8-day assessment window.* 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 *be set for* no later than the eighth day of posthospital SNF care. Consequently, if the ARD for the *initial Medicare* assessment prescribed in 42 CFR 413.343(b) is set *for* day 9, or later, the administrative level of care presumption does not apply. The coverage that arises from this presumption remains in effect *only* for as long thereafter as it continues to be supported by the facts of the beneficiary's condition and care needs. *Accordingly, the SNF is expected to monitor carefully for and document any changes in the patient's condition, in order to determine the continuing need for Part A SNF benefits after the ARD. Moreover,* this administrative presumption does not apply to any 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 *initial Medicare* 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.

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 *Medicare* assessment only when that assessment occurs

directly following the beneficiary's *discharge from the qualifying* hospital stay *(i.e., the hospital discharge and subsequent SNF admission both occur on the same day)*.

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 *initial Medicare* assessment, which must *be set for* 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, *a new initial Medicare assessment under the regulations at 42 CFR 413.343(b) would be required if the beneficiary's absence from the SNF exceeds the 3-day interruption window specified under the SNF PPS's interrupted stay policy (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 6, §120.2). In this scenario,* there is a presumption that he or she meets the level of care criteria upon *direct* readmission *from the hospital* 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. *The resulting* presumption of coverage lasts through the assessment reference date *(ARD)* of that assessment, which must *be set for* no later than the eighth day of the stay. *Alternatively, if the absence from the SNF does not exceed the 3-day interruption window, the beneficiary's return to the same SNF would represent a continuation of the previous SNF stay; as such, there would be no new initial Medicare assessment and no new presumption of coverage; however, any days remaining from the previous presumption would continue to apply through the ARD of the original assessment.*

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 *assessment* schedule *would* not 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 *initial Medicare* 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 *qualifying* hospital *stay* for a covered Part A *SNF* 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 *to a* ***non-hospital*** *setting* and then subsequently readmitted *to the SNF beyond the 3-day interruption window as described in scenario 3 above*,

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). *Alternatively, if the absence from the SNF does not exceed the 3-day interruption window, the beneficiary's return to the same SNF would represent a continuation of the previous SNF stay; as such, any days remaining from the previous presumption would continue to apply through the ARD of the original assessment.*

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 *directly* 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 *hospital* 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.

30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

EXAMPLE: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because *sufficient* supervision and assistance could not be arranged for the patient in his home. In these

circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

30.7.1 - The Availability of Alternative Facilities or Services

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

A3-3132.6.A, SNF-214.6.A

Alternative facilities or services may be available to a patient when health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

EXAMPLE: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that Medicare cannot cover such care is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare payment could not be made for the services because *an* expense limitation *(if* applicable*)* to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case

Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

A3
-3132.6.B, SNF-214.6.B

If the *A/B MAC (A)* determines that an alternative setting is available to provide the needed care, it considers whether the use of the alternative setting would actually be more economical in the individual case.

EXAMPLE 1:

If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

EXAMPLE 2:

If needed care could be provided in the home, but the patient’s residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

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

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

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 - *40.6*.

70.4 - Services Furnished Under Arrangements

(Rev.261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

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*. This means, for example, that payments by the SNF to an outside supplier for bundled services furnished to the SNF's Part A resident under an arrangement made with the outside supplier are not governed by the specific Medicare fee schedule amounts or claims processing timeframes that would apply to services billed to Medicare separately under Part B*; 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.

The arrangement must also comply with the fraud and abuse laws (see *Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 1, section 20.3, and* Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 80.5). Questions about the interpretation and enforcement of the statutory anti-kickback provisions in section 1128B(b) of the Social Security Act should be directed to the attention of the Industry Guidance Branch in HHS's Office of the Inspector General (OIG); see the regulations at 42 CFR Part 1008 and the OIG website at https://oig.hhs.gov/compliance/advisory-opinions/index.asp.