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 101	**Date: September 16, 2016**
	Change Request 9748

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

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: October 18, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 18, 2016

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	4/40/Certification and Recertification by Physicians 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: 101	Date: September 16, 2016	Change Request: 9748

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

Pub 100-01, Chapter 4, §40:

The second paragraph of this section is revised by adding an appropriate cross-reference at the end.

Pub 100-01, Chapter 5, §10.2:

The final paragraph of this section is revised by adding an appropriate cross-reference at the end.

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	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9748 - 01.1	Contractors and impacted providers shall be aware of the updates to Pub 100-01, Chapter 4, §40.	X	X							Hospital, Providers, SNF
9748 - 01.2	Contractors and impacted providers shall be aware of the updates to Pub 100-01, Chapter 5, §10.2.	X	X							Hospital, Providers, SNF

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9748 - 01.3	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 General Information, Eligibility, and Entitlement

Chapter 4 - Physician Certification and Recertification of Services

40 - Certification and Recertification by Physicians for Extended Care Services

(Rev. 101, Issued: 09-16-16, Effective: 10-18-16, Implementation: 10-18-16)

Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required certification and recertification statements and for retaining them in file for verifications, if needed, by the *A/B MAC (A)*. The skilled nursing facility determines the method by which the certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and recertification statements may be entered on or included in forms, NOTEs, or other records that would normally be signed in caring for a patient, or a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed. *See Pub. 100-08, Medicare Program Integrity Manual, chapter 6, section 6.3 regarding medical review of certification and recertification in SNFs.*

If the facility's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's or physician extender's refusal to certify based on other grounds (e.g., an objection in principle to the concept of certification and recertification), the facility may not bill the program or the beneficiary for covered items or services. The provider agreement, which the facility files with the Secretary, precludes it from charging the patient for covered items and services.

If a physician or physician extender refuses to certify because, in his/her opinion, the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition), the services are not covered and the facility can bill the patient directly. The reason for the refusal to make the certification must be documented in the facility records. For such documentation to be adequate, there must be some statement in the facility's records, signed by a physician or a responsible facility official, indicating that the patient's physician or physician extender feels that the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition).

Medicare General Information, Eligibility, and Entitlement
Chapter 5 - Definitions

10.2 - Admission of Medicare Patients for Care and Treatment
(Rev. 101, Issued: 09-16-16, Effective: 10-18-16, Implementation: 10-18-16)

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))*.