| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-02 Medicare Benefit Policy | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 228** | **Date: October 13, 2016** |
| | **Change Request 9748** |

**Transmittal 227, dated September 16, 2016, is being rescinded and replaced by Transmittal 228, dated October 13, 2016, to revise chapter 8 to correct minor omissions in sections 10.2 and 70. Additionally, section 20 is being removed from the Change Request altogether in order to rescind unclear wording that Transmittal 227 had inadvertently introduced. All other information, including the revisions to Pub. 100-01 and Pub. 100-04, remains the same.**

**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 | 8/10/Requirements - General |
| R | 8/10.1/Medicare SNF PPS Overview |
| R | 8/10.2/Medicare SNF Coverage Guidelines Under PPS |
| R | 8/10.3/Hospital Providers of Extended Care Services |
| R | 8/20.1/Three-Day Prior Hospitalization |
| R | 8/20.1.1/Three-Day Prior Hospitalization - Foreign Hospital |
| R | 8/20.2.2.5/Effect on Spell of Illness |
| R | 8/50.7/Medical Service of an Intern or Resident-in-Training |
| R | 8/70/Medical and Other Health Services Furnished to SNF Patients |
| R | 8/70.4/Services Furnished Under Arrangements With Providers |
| R | 15/110.1/Definition of Durable Medical Equipment |

## 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: 228 | Date: October 13, 2016 | Change Request: 9748 |
| --- | --- | --- | --- |

**Transmittal 227, dated September 16, 2016, is being rescinded and replaced by Transmittal 228, dated October 13, 2016, to revise chapter 8 to correct minor omissions in sections 10.2 and 70. Additionally, section 20 is being removed from the Change Request altogether in order to rescind unclear wording that Transmittal 227 had inadvertently introduced. All other information, including the revisions to Pub. 100-01 and Pub. 100-04, remains the same.**

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

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

## 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, §10:**

In the paragraph immediately following the seven bullet points, the word "status" has been deleted from the phrase "observation status". This clarification is necessary in order to reflect the longstanding policy that the term "observation" denotes an *outpatient service* rather than a *patient status*, and also to conform the text with a similar revision that was made previously in §20.1 of this chapter by CR 8997.

In addition, the final paragraph of this section is revised by adding an appropriate cross-reference.

**Pub 100-02, Chapter 8, §10.1:**

This section is revised by adding appropriate additional cross-references.

**Pub 100-02, Chapter 8, §10.2:**

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

**Pub 100-02, Chapter 8, §10.3:**

The existing cross-reference appearing at the end of the first paragraph of this section is corrected and another appropriate cross-reference is added.

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

**Pub 100-02, Chapter 8, §20.1:**

The first paragraph of this section is revised to address recurring confusion over the specific statutory basis for the requirement that discharge from the 3-day qualifying hospital stay cannot predate the beneficiary's Medicare eligibility. This confusion stems from the placement of the statutory authority for this coverage provision in title II of the Social Security Act (the Act) along with the general provisions on attaining

eligibility under the Medicare program, rather than in title XVIII of the Act where most of the SNF coverage provisions appear.

**Pub 100-02, Chapter 8, §20.1.1:**

In the opening paragraph of this section, the first cross-reference is updated and the second cross-reference is clarified.

**Pub 100-02, Chapter 8, §20.2.2.5:**

This section is revised by adding an appropriate cross-reference and correcting a typographical error.

**Pub 100-02, Chapter 8, §50.7:**

The initial paragraph in this section is revised by adding an appropriate cross-reference.

**Pub 100-02, Chapter 8, §70:**

The next-to-last paragraph in this section is revised by adding clarifying language and appropriate cross-references.

**Pub 100-02, Chapter 8, §70.4:**

The final paragraph in this section is revised by adding clarifying language and an appropriate cross-reference.

**Pub 100-02, Chapter 15, §110.1.D:**

The initial paragraph in subsection D of this section is revised to reflect the change in nomenclature for Medicaid intermediate care facilities (ICFs) from an ICF for the mentally retarded (ICF/MR) to an ICF for individuals with intellectual disabilities (ICF/IID), as discussed in a CMS final rule published in the *Federal Register* on May 16, 2012 (77 FR 29021-22).

**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 | |
| 9748 - 02.1 | Contractors and impacted providers shall be aware of the updates to Pub 100-02, Chapter 8. | X | X | | | | | | | Hospital, Providers, SNF |
| 9748 - 02.2 | Contractors shall be aware of the updates to Pub 100-02, Chapter 15, §110.1.D. The initial paragraph in subsection D of this section is revised to reflect the change in nomenclature for Medicaid | X | X | | | | | | | Hospital, Providers, SNF |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | intermediate care facilities (ICFs) from an ICF for the mentally retarded (ICF/MR) to an ICF for individuals with intellectual disabilities (ICF/IID), as discussed in a CMS final rule published in the Federal Register on May 16, 2012 (77 FR 29021-22). | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 9748 - 02.3 | 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 Benefit Policy Manual
## Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

### 10 - Requirements - General
*(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)*

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 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 *(see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 90.1)*.

## 10.1 - Medicare SNF PPS Overview

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

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 *also Pub. 15-1, Provider Reimbursement Manual, chapter* 28, *s*ection 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.*

## 10.2 - Medicare SNF Coverage Guidelines Under PPS

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

Under SNF PPS, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay other than the following:

- Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services, certain dialysis-related services, erythropoietin (EPO) for certain dialysis patients, hospice care related to a terminal condition, ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge, ambulance transportation related to dialysis services, certain services involving chemotherapy and its administration, radioisotope services, certain customized prosthetic devices and, for services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

Certain additional outpatient hospital services (along with ambulance transportation that convey a beneficiary to a hospital or CAH to receive the additional services) are excluded from coverage under SNF PPS and are billed separately. The additional services are:

- Cardiac catheterization services;
- Computerized axial tomography (CT scans);
- Magnetic resonance imaging (MRIs);
- Radiation therapy;
- Ambulatory surgery involving the use of a hospital operating room;
- Emergency services;
- Angiography services; and
- Lymphatic and venous procedures.

The CMS identifies the above services using HCPCS codes that are periodically updated. The CMS publishes the HCPCS coding changes in each year *via a Recurring Update Notification*. Other updates for the remaining quarters of the FY will occur as needed due to the creation of new temporary codes representing services included in SNF PPS prior to the next annual update. *To view the online code list of*

*exclusions from consolidated billing (CB, the SNF "bundling" requirement), go to the CB Overview page at [www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html](www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html) and proceed as follows:*

- *In the left-hand column of the CB Overview page, scroll down to the applicable Part A MAC (Medicare Administrative Contractor) Update to access the list of excluded codes that are billable by institutional providers (similar information is available for practitioners and other noninstitutional suppliers on the applicable Part B MAC Update). To view the most current update (the one that displays the most recent set of revisions to the code list), click on the "Part A MAC Update" link for the current year. This directs to a page that lists by Major Category (indicating the type of service) the specific changes in coding for this year.*

- *To see a complete list of the CB exclusions (along with the ambulatory surgery and Part B therapy **inclusions**), scroll down the Part A MAC Update page to the "Downloads" section. Then, click on the link to the zipped file entitled "Annual SNF Consolidated Billing HCPCS Updates" for the current year. Once this file is unzipped, the complete exclusion list can be selected in either Microsoft Excel or Text formats, and can then be searched for individual codes.*

- *For a general explanation of the types of services encompassed by each of the Major Categories, scroll down the Part A MAC Update page to the "Downloads" section, and click on the link to the "General Explanation of the Major Categories." (For example, Major Category III.A lists the excluded chemotherapy codes, and Major Category III.B lists the excluded chemotherapy administration codes.)*

*For further information on the SNF CB provision, see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 10 through 20.6.*

## 10.3 - Hospital Providers of Extended Care Services

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

In order to address the shortage of rural SNF beds for Medicare patients, rural hospitals with fewer than 100 beds may be reimbursed under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries. Such a hospital, known as a swing bed facility, can "swing" its beds between the hospital and SNF levels of care, on an as-needed basis, if it has obtained a swing bed approval from the Department of Health and Human Services. See *Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual,* Chapter *5, Section 30.3 ("Hospital Providers of Extended Care Services")* for a description of general rules applicable to *SNF-level services furnished in* hospital swing beds*; also, see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 100ff regarding SNF PPS billing procedures for SNF-level services furnished in rural (non-CAH) swing-bed hospitals*.

When a hospital is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules. This means that services provided in the swing bed are subject to the same Part A coverage, deductible, coinsurance and physician certification/recertification provisions that are applicable to SNF extended care services. The SNF coverage provisions are set forth in 42 CFR 409 Subpart D and are more fully explained in this chapter. A patient in a swing bed cannot simultaneously receive coverage for both SNF-level services under Part A and inpatient hospital ancillary services under Part B.

Swing bed patients who no longer qualify for Part A coverage of SNF-level services under the Medicare program (due to exhaustion of Part A SNF benefits, dropping below a SNF level of care, etc.) revert to receipt of a hospital level of care in the swing bed (see the Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," §10). Thus, any further Medicare coverage in the swing bed would be for inpatient hospital ancillary services under Part B, notwithstanding a patient's eligibility for Medicaid NF coverage.

A dually-eligible patient who continues to receive a SNF level of care or who has dropped below the SNF level may nonetheless still qualify for Medicaid coverage of nursing facility (NF) services, if the hospital

has a Medicaid swing bed agreement that has been approved by the State in which the facility is located. Such agreements permit Medicaid-participating rural hospitals to use their beds interchangeably to furnish both acute hospital care and NF care to Medicaid recipients, when no beds are available in area nursing facilities *(see Pub. 45, State Medicaid Manual, chapter 4, section 4560)*.

## 20.1 - Three-Day Prior Hospitalization

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

*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 of 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" 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. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

A stay of *3* or more days in a hospital outside the United States may satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States if the foreign hospital is qualified as an "emergency hospital" (see *Pub 100-04, Medicare Claims Processing Manual,* chapter *32*, §§*350ff.* for a description of foreign and emergency services payable by Medicare. Also 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.

## 20.2.2.5 - Effect on Spell of Illness

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

In the infrequent situation where the patient has been discharged from the hospital to his or her home more than 60 days before he or she is ready to begin a course of deferred care in a SNF, a new spell of illness begins with the day the beneficiary enters the SNF thereby generating another 100 days of extended care benefits *(see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, section 10.4.1)*. Another qualifying hospital stay would not be required, providing the care furnished is clearly related to *a* hospital stay in the previous spell of illness and represents care for which the need was predicted at the time of discharge from such hospital stay.

## 50.7 - Medical Service of an Intern or Resident-in-Training

*(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)*

The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the facility has in effect the required transfer agreement are covered under hospital insurance *(see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, section 30.2 for a discussion of the SNF's required transfer agreement with a hospital)*.

An "approved teaching program" means a program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The medical and surgical services furnished to the facility's patients by interns and residents-in-training of a hospital with which the facility has a transfer agreement are covered under medical insurance if the services are not covered under hospital insurance.

## 70 - Medical and Other Health Services Furnished to SNF Patients

*(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)*

The medical and other health services listed below are covered under Part B when furnished by a participating SNF either directly or under arrangements to inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met).

Services payable under Part B are:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, "Covered Medical and Other Health Services," §220.1.4);
- Screening mammography services;
- Screening pap smears and pelvic exams;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Some colorectal screening;

- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors.
- Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

See Pub. 100-04, Medicare Claims Processing Manual chapter 6, for information on billing for these services. See §70.1 of this chapter for the conditions under which diagnostic services and radiological therapy furnished by SNFs are covered. For coverage of total parenteral nutrition (TPN) and enteral nutrition (EN) as a prosthetic device, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," and the Medicare National Coverage Determinations Manual, chapter 1, Part 3, §180.2.

Rental or purchase of durable medical equipment from SNFs for use in the patient's home *(other than a hospital or SNF, as discussed in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, §110.1.D)* is covered under Part B in accordance with the provisions of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," §80 *(also see Pub. 100-04, Medicare Claims Processing Manual, chapter 7, §60, for the related SNF billing instructions)*. DME rendered to *Part A* inpatients of a SNF is covered as part of the prospective payment system and is not separately payable. For coverage of provider ambulance services, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B".

Drugs, biologicals, and blood are not covered under Part B when furnished by a SNF.

## 70.4 - Services Furnished Under Arrangements With Providers

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

The SNFs may arrange with others to furnish covered Part B 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.

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*.

# Medicare Benefit Policy Manual

## Chapter 15 – Covered Medical and Other Health Services

### 110.1 - Definition of Durable Medical Equipment

***(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)***

Durable medical equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

The following describes the underlying policies for determining whether an item meets the definition of DME and may be covered.

**A. Durability**

An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

**B. Medical Equipment**

Medical equipment is equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (hospitals, medical schools, medical societies) and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

**1. Equipment Presumptively Medical**

Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines, and traction equipment presumptively constitute medical equipment. (Although hemodialysis equipment is covered as a prosthetic device (§120), it also meets the definition of DME, and reimbursement for the rental or purchase of such equipment for use in the beneficiary's home will be made only under the provisions for payment applicable to DME. See the Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease," §30.1, for coverage of home use of hemodialysis.) **NOTE:** There is a wide variety in types of respirators and suction machines. The *DME*

*MACs* medical staff should determine whether the apparatus specified in the claim is appropriate for home use.

### 2. Equipment Presumptively Nonmedical

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered DME. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, and posture chairs, do not constitute medical equipment. Similarly, physical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature.

### 3. Special Exception Items

Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating that they are highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use.

**NOTE:** The above items represent special exceptions and no extension of coverage to other items should be inferred.

## C. Necessary and Reasonable

Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. These considerations will bar payment for equipment which cannot reasonably be expected to perform a therapeutic function in an individual case or will permit only partial therapeutic function in an individual case or will permit only partial payment when the type of equipment furnished substantially exceeds that required for the treatment of the illness or injury involved.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements;" §60, regarding the rules for providing advance beneficiary notices (ABNs) that advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to

make an informed consumer decision about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.

**1. Necessity for the Equipment**

Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the patient's illness or injury or to the improvement of his or her malformed body member. In most cases the physician's prescription for the equipment and other medical information available to the *DME MAC* will be sufficient to establish that the equipment serves this purpose.

**2. Reasonableness of the Equipment**

Even though an item of DME may serve a useful medical purpose, the *DME MAC* or *A/B MAC (A)* must also consider to what extent, if any, it would be reasonable for the Medicare program to pay for the item prescribed. The following considerations should enter into the determination of reasonableness:

1. Would the expense of the item to the program be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment?

2. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?

3. Does the item serve essentially the same purpose as equipment already available to the beneficiary?

**3. Payment Consistent With What is Necessary and Reasonable**

Where a claim is filed for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition or where there exists a reasonably feasible and medically appropriate alternative pattern of care which is less costly than the equipment furnished, the amount payable is based on the rate for the equipment or alternative treatment which meets the patient's medical needs.

The acceptance of an assignment binds the supplier-assignee to accept the payment for the medically required equipment or service as the full charge and the supplier-assignee cannot charge the beneficiary the differential attributable to the equipment actually furnished.

**4. Establishing the Period of Medical Necessity**

Generally, the period of time an item of durable medical equipment will be considered to be medically necessary is based on the physician's estimate of the time that his or her patient will need the equipment. See the Medicare Program Integrity Manual, Chapters 5 and 6, for medical review guidelines.

**D. Definition of a Beneficiary's Home**

For purposes of rental and purchase of DME a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for *individuals with intellectual disabilities (ICF/IID))*. However, an institution may not be considered a beneficiary's home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME. This is because such an institution may not be considered the individual's home. The same concept applies even if the patient resides in a bed or portion of the institution not certified for Medicare.

If the patient is at home for part of a month and, for part of the same month is in an institution that cannot qualify as his or her home, or is outside the U.S., monthly payments may be made for the entire month. Similarly, if DME is returned to the provider before the end of a payment month because the beneficiary died in that month or because the equipment became unnecessary in that month, payment may be made for the entire month.