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 84	**Date: April 4, 2014**
	Change Request 8669

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

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions including (but not limited to) changes relating to three previous Change Requests: 6030, 7701, and 8044. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

EFFECTIVE DATE: May 5, 2014
IMPLEMENTATION DATE: May 5, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4 / 40 / Certification and Recertification by Physicians for Extended Care Services
R	4 / 40.1 / Who May Sign the Certification or Recertification for Extended Care Services
R	4 / 80 / Summary Table for Certifications/Recertifications

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 obliged 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
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-01	Transmittal: 84	Date: April 4, 2014	Change Request: 8669

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions including (but not limited to) changes relating to three previous Change Requests: 6030, 7701, and 8044. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

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	
8669.1	Contractors shall be aware of the updates to Pub. 100-01 Chapter 4.	X	X							Hospital, Providers, SNF

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): Anthony Hodge, Anthony.Hodge@cms.hhs.gov , Bill Ullman, 410-786-5667 or william.ullman@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4

40 - Certification and Recertification by Physicians for Extended Care Services

(Rev, 84, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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 intermediary. 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* sign*ed* 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.

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* object*ion* 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 a*n 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)*.

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

Rev, 84, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a *physician extender (that is, a* nurse practitioner*,* a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

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

80 - Summary Table for Certifications/Recertifications

Rev, 84, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

The following is a table summarizing the certification/recertification signature requirements and timeframes for various provider types. Please review sections above for more detailed information on Certifications/Recertifications and their required content:

	Who Signs Certification	Certification Timeframe	Recertification
Hospital Inpatient	Attending physician or by another physician with knowledge of the case with authorization from attending physician or by a member of hospital's medical staff with knowledge of the case.	No later than the 12th day of hospitalization	Interval between recertifications not to exceed 30 days
SNF	Attending physician or physician on staff at SNF with knowledge of case*, or physician extender as discussed in §40.1 of this chapter*	Obtain at time of admission or shortly thereafter	First recertification no later than the 14th day of inpatient extended care services. Subsequent at intervals not exceeding 30 days.
HHA	Attending physician	Obtain at time POC is established or shortly thereafter	Physician must recertify at least once every 60 days
Hospice	For initial 90-day period, must obtain written certification statements from medical director of hospice or physician member of the hospice interdisciplinary group and the attending physician.	If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained.	Must be obtained for each period of hospice care; written certification by hospice medical director or physician member of interdisciplinary group.