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 94	**Date: October 16, 2015**
	Change Request 9336

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (2015)

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: November 16, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 16, 2015

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	Chapter 1 / 10.1 / Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description
R	Chapter 4 / 10.6 / Criteria for Continued Inpatient Hospital Stay

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: 94	Date: October 16, 2015	Change Request: 9336

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (2015)

EFFECTIVE DATE: November 16, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 16, 2015

I. GENERAL INFORMATION

A. Background: 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.

Pub. 100-01, Chapter 1:

In §10.1, the final paragraph's discussion about tracking the utilization of Part A benefit days (as added previously by CR 8044) is clarified by removing the inappropriate reference to utilization of home health services, which is actually measured in terms of visits rather than benefit days.

Pub. 100-01, Chapter 4:

Pursuant to the reference to "alternate placement" days that was added previously by CR 8044 and CR 8669 to the fifth paragraph of §20.1 of the Medicare Benefit Policy Manual, Chapter 8, §10.6 is revised to provide a more complete explanation on coverage of such alternate placement days spent in a hospital when a hospital inpatient's care needs have dropped from acute- to SNF-level but no SNF bed is available.

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	
9336 - 01.1	Contractors shall be aware of the updates to Pub. 100-01 Chapter 1: In §10.1, the final paragraph's discussion about tracking the utilization of Part A benefit days (as added previously by CR 8044) is clarified by removing the inappropriate reference to utilization of home health services, which is actually measured in terms of visits rather than benefit days.	X	X							Hospital, Providers, SN
9336 - 01.2	Contractors shall be aware of the updates to Pub. 100-	X	X							Hospital,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	01 Chapter 4: Pursuant to the reference to "alternate placement" days that was added previously by CR 8044 and CR 8669 to the fifth paragraph of §20.1 of the Medicare Benefit Policy Manual, Chapter 8, §10.6 is revised to provide a more complete explanation on coverage of such alternate placement days spent in a hospital when a hospital inpatient's care needs have dropped from acute- to SNF-level but no SNF bed is available.									Providers, SN

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9336 - 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				

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:

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

10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description

Rev.94, Issued: 10-16-15, Effective: 11-16-15 Implementation: 11-16-15)

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of posthospital extended care services.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

The Part A benefit categories *of* inpatient hospital services *and* SNF services are *each* subject to separate and mutually exclusive day limits, so that the use of benefit days under one of these benefits does not affect the number of benefit days that remain available under the other. *Accordingly*, the 90 days of inpatient hospital benefits (plus 60 nonrenewable lifetime reserve days -- see Pub. 100-02, Medicare Benefit Policy Manual, chapter 5) that are available to a beneficiary in a hospital *do not* count against the 100 days of posthospital extended care benefits that are available in a SNF, and vice-versa.

10.6 - Criteria for Continued Inpatient Hospital Stay

(Rev.94, Issued: 10-16-15, Effective: 11-16-15 Implementation: 11-16-15)

A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. *In accordance with the regulations at 42 CFR 424.13(c), a* physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available. *Coverage of these additional, "alternate placement" days in the hospital can continue until the earliest of the following events occurs:*

- *A bed becomes available in a participating SNF;*
- *The beneficiary's care needs drop below SNF-level; or*
- *The beneficiary has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period.*