CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2911	**Date: March 14, 2014**
	Change Request 8644

NOTE: Transmittal 2911 is being re-communicated due to an incorrect implementation date on the original communication. The implementation date has been corrected on this communication. The transmittal number, issue date, and all other information remain the same.

SUBJECT: Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to Jimmo vs. Sebelius

I. SUMMARY OF CHANGES: To edit language in the current SNF ABN section of Chapter 30 to ensure the manual instructions comport with Jimmo vs. Sebelius.

EFFECTIVE DATE: December 6, 2013
IMPLEMENTATION DATE: March 25, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/70.4.5/Proper Denial Paragraphs

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

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SUBJECT: Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to Jimmo vs. Sebelius

EFFECTIVE DATE: December 6, 2013
IMPLEMENTATION DATE: March 25, 2014

I. GENERAL INFORMATION

A. Background: To edit language in the current SNF ABN section of Chapter 30 to ensure the manual instructions comport with Jimmo vs. Sebelius.

B. Policy: N/A

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	
8644.1	Contractors shall be aware of the new policy in chapter 30, section 70.4.5.	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): Janet Miller, 404-562-1799 or janet.miller@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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70.4.5 - Proper Denial Paragraphs

(Rev. 2911, Issued: 03-14-14, Effective: 12-06-13, Implementation: 03-25-14)

The denial paragraphs (found below under Condition) cover common reason(s) why the extended care items or services are noncovered under Medicare. The SNF may use these denial paragraphs as inserts in the "Because" and "Items or Services" sections of the SNFABN (see §§70.4.3.2 and 70.4.3.3). Where no paragraph exists to explain the reason(s) why the extended care items or services are believed to be noncovered, the SNF is to develop new, or modify current, language to fit the situation. The SNF is to forward the newly prepared language to the Medicare contractor associated with processing its Medicare claims. The associated Medicare contractor will submit the SNF's language to CMS for review and, as appropriate, for inclusion in the MCPM.

NOTE: If applicable, the SNF is to substitute therapy and type of therapist for skilled nursing and skilled nurse. If applicable, the SNF is to substitute URC for "we" (e.g., "we or URC believe that the services you (the patient) received are noncovered."). If applicable, the SNF is to adjust the verb reflections or tense for those paragraphs containing admission denial information.

Condition: Nonskilled care - full denial
Denial Paragraph: Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

Condition: Specific nonskilled service provided - no skilled care (full denial)
Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service). This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Specify nonskilled service provided - (partial denial)
Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service) after (date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (date) is not covered under Medicare.

Condition: Observation and management of care plan - no significant change
Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning (date) to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe you stay after (date) is not covered under Medicare.

Condition: Observation and management of care plan - condition improved
Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition, you needed a skilled nurse from (date) through (date) to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by nonskilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare after (date).

Condition: Teaching and training activities - partial denial
Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform the tasks ordered by your physician by (date) but the therapist continued

services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning (date).

Condition: Teaching and training activities - no skilled service
Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

Condition: Teaching and training activities - little or no progress
Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after (date).

Condition: Nursing not needed for foley care
Denial Paragraph: Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere convenience or the control of incontinence. Since your catheter was inserted for convenience or the control or your incontinence, we believe that your care is not covered under Medicare.

Condition: Repetitive exercises - partial denial
Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning (date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after (date).

Condition: Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)
Denial Paragraph: Medicare covers medically necessary skilled rehabilitative services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (specify) therapist to perform and/or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare.

Condition: Therapy to maintain function after a maintenance program has been established
Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning (date), the (specify) therapy services you received were to carry out this program. These services do not require the supervision or skills of a (specify) therapist and, therefore, we believe that the services are not/would not be covered under Medicare.

Condition: Specific skilled service is not reasonable and necessary (service not specific or effective)
Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. The (specify service(s)) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not considered a specific and/or effective treatment for your condition. Since the service(s) you received was/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

Condition: Frequency not reasonable and necessary
Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Skilled rehabilitation services not received daily - no skilled nursing
Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare.

Condition: Skilled nursing services not daily
Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Although you required skilled nursing services, you do/did not need them on a daily basis. Because you do/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.