CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 183	**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	8 / 20.1 / Three-Day Prior Hospitalization
R	8 / 40 / Physician Certification and Recertification of Extended Care Services

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. 100-02	Transmittal: 183	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

EFFECTIVE DATE: May 5, 2014

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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. 100-02 Chapter 8.	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):
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.

Medicare Benefit Policy Manual, Chapter 8

20.1 - Three-Day Prior Hospitalization

(Rev. 183, Issued: 04- 04-14, Effective: 05-05-14, Implementation; 05-05-14)

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 status 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 intermediary's 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 intermediary 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, this conclusively establishes that the hospital stay *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 chapter 9, section 40.1.5 of the Medicare Benefit Policy Manual, 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.).

40 - Physician Certification and Recertification of Extended Care Services

(Rev. 183, 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 SNF must obtain and retain the *required* certification and recertification statements. The intermediary may request them to assist in determining medical necessity when necessary. The SNF will determine how to obtain the required certification and recertification statements. There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met. Certification or 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 on a separate form. Except as otherwise specified, each certification and recertification is to be *separately* signed.

If the SNF's failure to obtain a certification or recertification is not due to a question of the necessity for the services, but to the physician's *or physician extender's* refusal to certify on other grounds (e.g., *an* object*ion* in principle to the concept of certification and recertification), the SNF cannot charge the beneficiary for covered items or services. Its provider agreement precludes it from doing so.

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 SNF's records.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.

In addition, only physicians may certify outpatient physical therapy and outpatient speech-language pathology services.