CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 249	**Date: November 2, 2018**
	Change Request 11004

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)

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: December 4, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 4, 2018

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/ 10.1/ Medicare SNF PPS Overview
R	8/ 20.1/ Three-Day Prior Hospitalization
R	8/ 30.6/ Daily Skilled Services Defined
R	8/70.4/ Services Furnished Under Arrangements With Providers

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: 249	Date: November 2, 2018	Change Request: 11004

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)

EFFECTIVE DATE: December 4, 2018
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IMPLEMENTATION DATE: December 4, 2018

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. There are no policy changes.

Pub 100-02, Chapter 8, §10.1:

This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §20.1:

This section is revised to clarify that "general inpatient care" under the hospice benefit can count toward meeting the SNF benefit's qualifying hospital stay requirement only when actually furnished in the hospital setting.

Pub 100-02, Chapter 8, §30.6:

This section is revised to correct a typographical error.

Pub 100-02, Chapter 8, §70.4:

This section is revised to clarify that HHS's Office of the Inspector General (OIG) is the component that addresses questions on interpreting and enforcing the statutory anti-kickback provisions, and by adding an appropriate cross-reference.

B. Policy: These changes are intended to clarify the existing content; there are no policy changes.

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	
11004 - 02.1	Contractors and impacted providers shall be aware of the updates to Pub 100-02, Chapter 8.	X	X							Hospital, Providers,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
										SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11004 - 02.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	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

10.1 - Medicare SNF PPS Overview
(Rev.249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

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, *Part I,* chapter 28, section 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.

20.1 - Three-Day Prior Hospitalization
(Rev.249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

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" *furnished in a hospital* 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.).

30.6 - Daily Skilled Services Defined

(Rev.249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE:

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to "daily" skilled services. However, arbitrarily staggering the timing of various therapy modalities *through* the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a "daily basis." To meet this requirement, the patient must actually **need** skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is **furnished** each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the "daily basis" requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but **when** they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the "daily basis" requirement for SNF coverage would not be met.

70.4 - Services Furnished Under Arrangements With Providers

(Rev.249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

The SNF may arrange with others to furnish covered services such as 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. See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, section 10.3, for a general discussion of services furnished "under arrangements."

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.

The arrangement must also comply with the fraud and abuse laws (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 80.5). Questions about the interpretation and enforcement of the statutory anti-kickback provisions in section 1128B(b) of the Social Security Act should be directed to the attention of the Industry Guidance Branch in HHS's Office of the Inspector General (OIG); see the regulations at 42 CFR Part 1008 and the OIG website at https://oig.hhs.gov/compliance/advisory-opinions/index.asp.