

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 10880	Date: August 6, 2021
	Change Request 12009

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Medicare manuals to correct various minor technical errors and omissions and to reflect provisions of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

EFFECTIVE DATE: November 8, 2021

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

IMPLEMENTATION DATE: November 8, 2021

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	3/10.4.3/Definition of Hospital or SNF for Ending a Benefit Period
R	3/10.4.3.2/SNF Stay and End of Benefit Period

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**

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12009 - 01.2	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: 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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ATTACHMENTS: 0

10.4.3 - Definition of Hospital or SNF for Ending a Benefit Period

(Rev.10880, Issued: 08-06-21, Effective: 11-08- 21, Implementation: 11-08-21)

It is important to note that a benefit period cannot end while a beneficiary is an inpatient (*see §10.4.4*) of *an institution that meets the basic definition of a “hospital” at §1861(e)(1) of the Social Security Act (the Act)*, even if the hospital does not meet all of the *additional* requirements that are necessary for starting a benefit period, *as discussed further in §10.4.3.1 below (see also §1861(e) following (9) of the Act and the regulations at 42 CFR 409.60(b)(1))*. Similarly, a benefit period cannot end while a beneficiary is an inpatient (*see §10.4.4*) of *an institution that meets the basic definition of a “SNF” at §1819(a)(1) of the Act*, as *discussed further in §10.4.3.2* below.

As noted in §2164 of the State Operations Manual (Pub. 100-07), Chapter 2, all hospitals and SNFs that are Medicare-certified are automatically considered to meet the applicable basic definition in this context by reason of the Medicare certification itself. Moreover, even an institution (or portion of an institution) that is not certified for Medicare can serve to prolong an inpatient’s benefit period if it meets either the basic “hospital” or “SNF” definition discussed above.

10.4.3.2 - SNF Stay and End of Benefit Period

(Rev.10880, Issued: 08-06-21, Effective: 11-08- 21, Implementation: 11-08-21)

Similarly, to end a benefit period, a beneficiary cannot have been an inpatient (*see §10.4.4*) of a SNF for at least 60 consecutive days; where SNF is defined *in accordance with §§1861(a)(2) and 1819(a)(1) of the Social Security Act* as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. *As indicated above in §10.4.3, all Medicare-certified SNFs (including Medicare-certified distinct part SNFs) are automatically considered to meet this basic “SNF” definition by reason of the Medicare certification itself. See §2166 of the State Operations Manual (Pub. 100-07), Chapter 2, for the administrative criteria used in determining whether the basic “SNF” definition is met by a nursing home that is not Medicare-certified (including the noncertified portion of an institution that also contains a Medicare-certified distinct part SNF).*

Examples: An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

Example 1: X was born 8/9/1936. On 7/28/2001, X entered a participating general hospital. After he/she had been in the hospital for 2 weeks, X was discharged on 8/11/2001. On his/her doctor’s orders, X entered a participating SNF on 8/15/2001, and remained an inpatient there (*see §10.4.4*) until his/her discharge on 10/27/2001. He/she had no further inpatient stays in 2001.

X’s benefit period began on 8/1/2001, the first day of the month he/she attained age 65 and was entitled to hospital insurance. The benefit period ended 12/25/2001, the end of the 60-day period beginning with the date of his/her last discharge.

Example 2: Y, over age 65, entered a participating general hospital on 8/28/2000 for treatment of a heart condition. He/she was discharged on 9/11/2000. On 10/3/2000, Y entered a Medicaid-only nursing facility, and remained an inpatient of this facility (*see §10.4.4*) until his/her discharge on 11/17/2000. On 12/26/2000, Y was again admitted to a participating hospital because of injuries suffered in an accident. He/she was discharged on 1/13/2001 and had no further inpatient stays in 2001.

Y’s benefit period began on 8/28/2000. His/her stay in the nursing facility began less than 60 days after his/her hospital stay and the benefit period was continued because he/she remained an inpatient there (*see §10.4.4*) even though Medicare did not cover the stay. The subsequent hospital stay began less than 60 days after the nursing facility stay and continued the benefit period although the condition treated was unrelated

to his/her prior stays. The benefit period ended on 3/14/2001, the end of the 60-day period beginning with the day of last discharge.

Example 3: Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on 8/1/2000 and discharged on 8/10/2000, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements of an emergency hospital, Z's benefit period did not begin with his/her admission to this hospital because:

1. The hospital did not meet all of the requirements in the definition of a hospital; and
2. Although the hospital satisfied the minimum requirements for coverage of emergency services, Z did not receive emergency inpatient care there.

(As noted previously, a stay in an emergency hospital does not begin a benefit period unless it actually involves the receipt of covered inpatient emergency services; by contrast, even a nonemergency stay in such a hospital can serve as a qualifying hospital stay for purposes of coverage under the posthospital extended care benefit.) Z was admitted to Haven Convalescent Home on 8/20/2000 and remained an inpatient of the home (see §10.4.4) until his/her discharge on 3/1/2001. He/she had no further inpatient stays in 2001. Haven Convalescent Home became a participating SNF on 1/1/2001.

Z's benefit period began 1/1/2001, the day Haven Convalescent Home was determined to be a qualified SNF. The services Z received from that date through discharge were extended care services even though they were not covered and, therefore, not charged against Z's Medicare SNF utilization. (The services were not covered posthospital extended care services because Z was not admitted to a participating SNF within 30 days after discharge from the hospital.) Z's benefit period ended 4/29/2001, the end of the 60-day period beginning with the date of his discharge from the convalescent home.