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 114	**Date: March 16, 2018**
	Change Request 10512

Transmittal 114, dated March 16, 2018, as part of a companion package, is being re-issued to correct a typo in all the revision lines to correctly spell the word "Implementation" in Pub. 100-01, and in addition, to correct a spacing issue in Pub. 100-02, Transmittal 242, to create a spacing line between the heading for section 70.4 and the paragraph that follows. Transmittal number, date issued and all other information remains the same.

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

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: June 19, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 19, 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	4/ 40.1/ Who May Sign the Certification or Recertification for Extended Care Services
R	4/ 40.2/ Certification for Extended Care Services
R	5/ 30.2/ Transfer Agreements
R	5/ 30.3/ Hospital Providers 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 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: 114	Date: March 16, 2018	Change Request: 10512

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

EFFECTIVE DATE: June 19, 2018
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IMPLEMENTATION DATE: June 19, 2018

I. GENERAL INFORMATION

A. Background: This CR updates the Medicare manuals with regard to SNF policy to clarify theexisting content. These changes are being made to correct various omissions and minor technical errors. Nopolicy, processing, or system changes areanticipated.

Pub 100-01, Chapter 4, §40.1:

This section is revised by adding an appropriate cross-reference.

Pub 100-01, Chapter 4, §40.2:

This section is revised by clarifying the discussion of the initial certification's required content, and by adding an appropriate cross-reference.

Pub 100-01, Chapter 5, §30.2:

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(n), in order to reflect their redesignation at 42 CFR 483.70(j) in the long-term care facility requirements reform final rule (81 FR 68831, October 4, 2016).

Pub 100-01, Chapter 5, §30.3:

This section is revised by updating the existing citation to the regulations at 42 CFR 482.66, in order to reflect their redesignation at 42 CFR 482.58 in a final rule that was published on May 12, 2014 (79 FR 27155), and by adding a reference to §10.3 of Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, for additional information on Part A coverage of SNF-level swing-bed services as extended care services.

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	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10512 - 01.1	Contractors and impacted providers shall be aware of the updates to Pub 100-01, Chapters 4 and 5.	X	X							Hospital, Providers, SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10512 - 01.2	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	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):
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ATTACHMENTS: 0

Medicare General Information, Eligibility, and Entitlement

Chapter 4 - Physician Certification and Recertification of Services

40.1 -Who May Sign the Certification or Recertification for Extended Care Services

(Rev.114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician. *See Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §40.1, for a discussion of "direct" and "indirect" employment relationships in this context.*

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in Chapter 5, §70 of this manual.

40.2 - Certification for Extended Care Services

(Rev.114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a *daily* basis for *an ongoing condition* for which he/she was receiving inpatient hospital services prior to transfer to the SNF *(or for a new condition that arose while in the SNF for treatment of that ongoing condition). Alternatively, under the regulations at 42 CFR 424.20(a)(1)(ii), the initial certification can simply affirm that the individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required SNF level of care, as provided in the regulations at 42 CFR 409.30 (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1, for a discussion of the administrative level of care presumption under the SNF PPS).* Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

Medicare General Information, Eligibility, and Entitlement
Chapter 5 - Definitions

30.2 - Transfer Agreements
(Rev.114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

To participate in the program, a SNF must have a written transfer agreement with one or more participating hospitals (see §10.1 of this chapter) providing for the transfer of patients between the hospital and the SNF, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See 42 CFR *483.70(j)* for the detailed requirements for transfer agreements.)

30.3 - Hospital Providers of Extended Care Services
(Rev.114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

In order to address the shortage of rural SNF beds for Medicare patients, rural hospitals with fewer than 100 beds may be reimbursed under Medicare Part A for furnishing post hospital extended care services to Medicare beneficiaries if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Such a hospital, known as a swing bed hospital, can "swing" its beds between hospital and SNF levels of care, on an as needed basis. In accordance with §1883 of the Act, rural hospitals with fewer than 100 beds must make application and request approval to be a swing bed hospital from the regional office. In order to obtain swing bed approval, the hospital must:

- As noted above, be located in a rural area (i.e., located outside of an "urbanized area," as defined by the Census Bureau and based on the most recent census, see 42 CFR *482.58(a)(2)*) and have fewer than 100 beds (excluding intensive care-type beds and newborn bassinets)

- Have a Medicare provider agreement, as a hospital;

- Be substantially in compliance with the SNF participation requirements identified in 42 CFR *482.58*; (most other SNF participation requirements would be largely met by virtue of the facility's compliance with comparable hospital conditions);

- Not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c); and

- Not have had a swing bed approval terminated within the 2 years previous to application for swing bed participation.

However, the Department may grant swing bed approval, on a demonstration basis, with hospitals meeting all of the statutory requirements except bed size and geographic location.

Prior to October 1, 1990, a swing-bed hospital could also furnish intermediate care facility (ICF) type services to non-Medicare patients. Effective with services furnished on or after October 1, 1990, the distinction between SNFs and ICFs for certifying a facility for the Medicaid program was eliminated. Thus, for purposes of the Medicaid program, facilities may no longer be certified as ICFs but instead may be certified only as nursing facilities (NFs) and can provide services as defined in §1919(a)(1) of the Act. Effective October 1, 1990, such services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients are referred to as NF-type services.

See §10.3 of Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, for additional information on Part A coverage of SNF-level swing-bed services as extended care services.