CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 161	**Date: October 26, 2012**
	Change Request 8044

SUBJECT: Manual Updates to Clarify SNF Claims Processing

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to clarify key components of SNF claims processing. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated. The updated manuals and sections are as follows: Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapters 1 and 3; Pub. 100-02, Medicare Benefit Policy Manual, chapters 8 and 15; and Pub. 100-04, Medicare Claims Processing Manual, chapter 6.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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	Chapter 8 / 20.1 / Three-Day Prior Hospitalization
R	Chapter 8 / 20.2.1 / General
R	Chapter 8 / 30.6 / Daily Skilled Services Defined
R	Chapter 15 / 110.1 / Definition of Durable Medical Equipment

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 Instructions

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 161	Date: October 26, 2012	Change Request: 8044

SUBJECT: Manual Updates to Clarify SNF Claims Processing

EFFECTIVE DATE: April 1, 2013
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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update the Medicare manuals to clarify key components of SNF claims processing. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated. The updated manuals and sections are as follows: Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapters 1 and 3; Pub. 100-02, Medicare Benefit Policy Manual, chapters 8 and 15; and Pub. 100-04, Medicare Claims Processing Manual, chapter 6.

B. Policy: This change request (CR) manualizes a number of policy clarifications pertaining to the skilled nursing facility (SNF) consolidated billing provision, including guidance issued previously in a series of Medicare Learning Network (MLN) Matters Special Edition articles on this subject.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8044.1	Contractors shall review and be aware of the manual revisions as they concern SNF claims processing.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8044.2	MLN Article : A provider education article related to	X	X		X	X		

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	this instruction will be available at http://www.cms.hhs.gov/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 one week of the availability of the provider education 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.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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, 410-786-6645 or 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) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

20.1 - Three-Day Prior Hospitalization
(Rev. 161, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

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(b) 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. 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.).

20.2.1 - General

(Rev. 161, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

A3-3131.3.A, SNF-212.3.A

Post-hospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are "post-hospital" if initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital services. In certain circumstances the 30-day period may be extended, as described in §20.2.2 below. *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 determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days. For example, a patient discharged from a hospital on August 1 and admitted to a SNF on August 31 was admitted within 30 days. The 30-day period begins on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care. Thus, an individual who is admitted to a SNF within 30 days after discharge from a hospital, but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement. (See §20.2.2 below for an exception under which such services may be covered.) *Conversely, as long as a covered level of care **is** needed and initiated in the SNF within the specified timeframe, the timely transfer requirement is considered to be met even if actual **Medicare payment** does not commence until later (for example, in a situation where another payment source that is primary to Medicare has assumed financial responsibility for the initial portion of the SNF stay).*

If an individual whose SNF stay was covered upon admission is thereafter determined not to require a covered level of care for a period of more than 30 days, payment could not be resumed for any extended care services he or she may subsequently require, even though he or she has remained in the facility*, until the occurrence of a new qualifying hospital stay*. *In the absence of a new qualifying hospital stay, s*uch services could not be deemed to be "post-hospital" extended care services. (For exception, see §20.2.2 below.)

30.6 - Daily Skilled Services Defined

(Rev. 161, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

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 exist 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 though 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.*

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

110.1 - Definition of Durable Medical Equipment

(Rev. 161, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

B3-2100.1, A3-3113.1, HO-235.1, HHA-220.1, B3-2100.2, A3-3113.2, HO-235.2, HHA-220.2

Durable medical equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

The following describes the underlying policies for determining whether an item meets the definition of DME and may be covered.

A. Durability

An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment

Medical equipment is equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (hospitals, medical schools, medical societies) and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

1. Equipment Presumptively Medical

Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines, and traction equipment presumptively constitute medical equipment. (Although hemodialysis equipment is covered as a prosthetic device (§120), it also meets the definition of DME, and reimbursement for the rental or purchase of such equipment for use in the beneficiary's home will be made only under the provisions for payment applicable to DME. See the

Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease," §30.1, for coverage of home use of hemodialysis.) **NOTE:** There is a wide variety in types of respirators and suction machines. The DMERC's medical staff should determine whether the apparatus specified in the claim is appropriate for home use.

2. Equipment Presumptively Nonmedical

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered DME. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, and posture chairs, do not constitute medical equipment. Similarly, physical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature.

3. Special Exception Items

Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating that they are highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use.

NOTE: The above items represent special exceptions and no extension of coverage to other items should be inferred

C. Necessary and Reasonable

Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. These considerations will bar payment for equipment which cannot reasonably be expected to perform a therapeutic function in an individual case or will permit only partial therapeutic function in an individual case or will permit only partial payment when the type of equipment furnished substantially exceeds that required for the treatment of the illness or injury involved.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements;" §60, regarding the rules for providing advance beneficiary notices (ABNs) that advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make an informed consumer decision about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.

1. Necessity for the Equipment

Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the patient's illness or injury or to the improvement of his or her malformed body member. In most cases the physician's prescription for the equipment and other medical information available to the DMERC will be sufficient to establish that the equipment serves this purpose.

2. Reasonableness of the Equipment

Even though an item of DME may serve a useful medical purpose, the DMERC or intermediary must also consider to what extent, if any, it would be reasonable for the Medicare program to pay for the item prescribed. The following considerations should enter into the determination of reasonableness:

1. Would the expense of the item to the program be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment?

2. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?

3. Does the item serve essentially the same purpose as equipment already available to the beneficiary?

3. Payment Consistent With What is Necessary and Reasonable

Where a claim is filed for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition or where there exists a reasonably feasible and medically appropriate alternative pattern of care which is less costly than the equipment furnished, the amount payable is based on the rate for the equipment or alternative treatment which meets the patient's medical needs.

The acceptance of an assignment binds the supplier-assignee to accept the payment for the medically required equipment or service as the full charge and the supplier-assignee cannot charge the beneficiary the differential attributable to the equipment actually furnished.

4. Establishing the Period of Medical Necessity

Generally, the period of time an item of durable medical equipment will be considered to be medically necessary is based on the physician's estimate of the time that his or her patient will need the equipment. See the Medicare Program Integrity Manual, Chapters 5 and 6, for medical review guidelines.

D. Definition of a Beneficiary's Home

For purposes of rental and purchase of DME a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution *(such as an assisted living facility, or an intermediate care facility for the mentally retarded (ICF/MR))*. However, an institution may not be considered a beneficiary's home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services

for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME. This is because such an institution may not be considered the individual's home. The same concept applies even if the patient resides in a bed or portion of the institution not certified for Medicare.

If the patient is at home for part of a month and, for part of the same month is in an institution that cannot qualify as his or her home, or is outside the U.S., monthly payments may be made for the entire month. Similarly, if DME is returned to the provider before the end of a payment month because the beneficiary died in that month or because the equipment became unnecessary in that month, payment may be made for the entire month.