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 80	**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 1 / 10.1 / Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description
R	Chapter 3 / 10.4.1 / Starting a Benefit Period
R	Chapter 3 / 10.4.2 / Ending a Benefit Period
R	Chapter 3 / 10.4.4 / Definition of Inpatient for Ending a Benefit Period

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. 100-01	Transmittal: 80	Date: October 26, 2012	Change Request: 8044

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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 General Information, Eligibility, and Entitlement

Chapter 1 - General Overview

10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description

(Rev. 80, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of posthospital extended care services.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

The various Part A benefit categories (inpatient hospital services, SNF services, home health services, etc.) are subject to separate and mutually exclusive day limits, so that the use of benefit days under one of these benefits does not affect the number of benefit days that remain available under any of the other benefits. For example, the 90 days of inpatient hospital benefits (plus 60 nonrenewable lifetime reserve days-- see Pub. 100-02, Medicare Benefit Policy Manual, chapter 5) that are available to a beneficiary in a hospital ***do not*** *count against the 100 days of posthospital extended care benefits that are available in a SNF, and vice-versa.*

Medicare General Information, Eligibility, and Entitlement

Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations

10.4.1 - Starting a Benefit Period

(Rev. 80, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.

A provider qualified to start a benefit period is a hospital (including a psychiatric hospital) or SNF that meets all the requirements of the definition of such an institution. A hospital which meets all requirements in Chapter 5, §20 of this manual is also a qualified hospital for purposes of beginning a benefit period when it furnishes the patient covered inpatient emergency services. Thus, generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual. However, the noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or a SNF which meets all requirements in the definition of such an institution even though it may not be participating. A qualified hospital in Canada or Mexico is also a qualified provider for purposes of beginning a benefit period when it furnishes covered inpatient hospital services. If a person is in a nonqualified institution and is subsequently transferred to a qualified hospital (general or psychiatric), his/her benefit period begins on admission to the qualified hospital.

Admission to a qualified SNF or to the SNF level of care in a swing-bed hospital begins a benefit period even though payment for the services cannot be made because the prior hospitalization or *thirty-day* transfer requirement has not been met. *It is also worth noting that the SNF benefit's "thirty-day" transfer requirement has a medical appropriateness exception (described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, section 20.2.2), under which the allowable interval between a beneficiary's discharge from a qualifying prior hospitalization and the initiation of SNF care can exceed the normal 30-day timeframe; moreover, in a situation where the allowable interval under this exception is **60 days** or longer, the subsequent commencement of extended care services in the SNF would serve to trigger the start of a new benefit period.* Inpatient care in a Religious Non-Medical Health Care Institution (whether as hospital or extended care services) can begin or prolong a benefit period.

10.4.2 - Ending a Benefit Period

((Rev. 80, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF. To determine the 60 consecutive day period, begin counting with the day the individual was discharged. (See §10.4.3.2 of this chapter for determining the end of a benefit period when an individual remains in a SNF.)

*As noted in section 10.4, the term "benefit period" is synonymous with spell of illness. However, the statutory language (at §1861(a) of the Social Security Act) that describes a benefit period as a "spell of illness" is sometimes misunderstood to mean that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and entirely unrelated condition could serve to end a benefit period even in the absence of a 60-day break in the beneficiary's "inpatient" status. In fact, the onset of a new condition is not, in itself, relevant to the ending of a benefit period, which can occur **only** through a 60-day break in inpatient status, as described above.*

10.4.4 - Definition of Inpatient for Ending a Benefit Period

(Rev. 80, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Generally, a beneficiary is an inpatient of a hospital if the beneficiary is receiving inpatient services in the hospital (i.e., not on an outpatient basis). The type of care actually received is not relevant.

However, a different definition of inpatient applies in determining the end of a benefit period for a beneficiary in a SNF*, under which such a* beneficiary is *considered* an inpatient *in this context* only if the beneficiary's care in the SNF meets certain skilled level of care standards. *Specifically, t*he beneficiary must need and receive a skilled level of care while in the SNF.

This means that in order to have been an *"*inpatient*" for benefit period purposes* while in a SNF, the beneficiary must have required and received skilled services on a daily basis which could, as a practical matter, only have been provided in a SNF on an inpatient basis. *(Under the regulations at 42 CFR 409.60(b)(2), an additional level of care criterion at 42 CFR 409.31(b)(2)--requiring that the SNF care must in some way relate back to a condition that was present during the beneficiary's qualifying hospital stay--does not apply to benefit period determinations.)* If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF for purposes of prolonging the benefit period. *Conversely, a beneficiary would remain an SNF "inpatient" in this context (thus prolonging his or her current benefit period) for as long as the beneficiary continues receiving a skilled level of care in the SNF--even if Part A payment has ended due to the beneficiary's exhaustion of SNF benefits.*

Use the following presumptions for determining whether the skilled level of care standards were met during a prior SNF stay.

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation on liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a non-certified bed.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules. (This presumption does not apply to placement in a non-certified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in a SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation.

Presumptions 5 through 7 can be rebutted by the beneficiary showing that the level of care needed or received is other than that which the presumption dictates.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. Specifically, the requirement referred to in Chapter 4, §40.2 regarding prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for a SNF stay on level of care grounds (i.e., not even waiver payment was made) because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when Medicare SNF payment is denied on level of care grounds, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption. Therefore, the previous references to Medicaid claims have been deleted from those presumptions which establish that an individual does meet the Medicare standards.

Medicare no-payment bills submitted by a SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no-payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no-payment bills which lead to Medicaid program payment determinations. If a SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, intermediaries request a SNF to submit one. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Where the presumptions are rebuttable (i.e., 5 through 7), rebuttal showings are permitted at both intermediary determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Intermediaries evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial.

This special rule for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is in exhausted or copay status and is seeking to renew a benefit period. The rule has equal application where it results in the beneficiary starting a new benefit period and paying a new deductible without receiving an increase in the amount of Medicare benefits paid.