

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-02 Medicare Benefit Policy</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 10880</b>	<b>Date: August 6, 2021</b>
	<b>Change Request 12009</b>

**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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	8/10.2/Medicare SNF Coverage Guidelines Under PPS
R	8/20.1/Three-Day Prior Hospitalization
R	8/40/Physician Certification and Recertification of Extended Care Services
R	15/110.1/Definition of Durable Medical Equipment

**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 - 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: 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):**

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

### 10.2 - Medicare SNF Coverage Guidelines Under PPS

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

Under SNF PPS, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay other than the following:

- Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services, certain dialysis-related services, erythropoietin (EPO) for certain dialysis patients, hospice care related to a terminal condition, ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge, ambulance transportation related to dialysis services, certain services involving chemotherapy and its administration, radioisotope services, certain customized prosthetic devices, *certain blood clotting factors* and, for services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

Certain additional outpatient hospital services (along with ambulance transportation that *conveys* a beneficiary to a hospital or CAH to receive the additional services) are excluded from coverage under SNF PPS and are billed separately. The additional services are:

- Cardiac catheterization services;
- Computerized axial tomography (CT scans);
- Magnetic resonance imaging (MRIs);
- Radiation therapy;
- Ambulatory surgery involving the use of a hospital operating room;
- Emergency services;
- Angiography services; and
- Lymphatic and venous procedures.

The CMS identifies the above services using HCPCS codes that are periodically updated. The CMS publishes the HCPCS coding changes in each year via a Recurring Update Notification. Other updates for the remaining quarters of the FY will occur as needed due to the creation of new temporary codes representing services included in SNF PPS prior to the next annual update. To view the online code list of exclusions from consolidated billing (CB, the SNF “bundling” requirement), go to the CB Overview page at [www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html](http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html) and proceed as follows:

- In the left-hand column of the CB Overview page, scroll down to the applicable Part A MAC (Medicare Administrative Contractor) Update to access the list of excluded codes that are billable by institutional providers (similar information is available for practitioners and other noninstitutional

suppliers on the applicable Part B MAC Update). To view the most current update (the one that displays the most recent set of revisions to the code list), click on the “Part A MAC Update” link for the current year. This directs to a page that lists by Major Category (indicating the type of service) the specific changes in coding for this year.

- To see a complete list of the CB exclusions (along with the ambulatory surgery and Part B therapy **inclusions**), scroll down the Part A MAC Update page to the “Downloads” section. Then, click on the link to the zipped file entitled “Annual SNF Consolidated Billing HCPCS Updates” for the current year. Once this file is unzipped, the complete exclusion list can be selected in either Microsoft Excel or Text formats, and can then be searched for individual codes.
- For a general explanation of the types of services encompassed by each of the Major Categories, scroll down the Part A MAC Update page to the “Downloads” section, and click on the link to the “General Explanation of the Major Categories.” (For example, Major Category III.A lists the excluded chemotherapy codes, and Major Category III.B lists the excluded chemotherapy administration codes.)

For further information on the SNF CB provision, see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 10 through 20.6.

## **20.1 - Three-Day Prior Hospitalization**

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

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, §130.2.A, when a beneficiary qualifies for limitation on 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, §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 (*see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §30.2 for a discussion of the SNF's required transfer agreement with a hospital*). 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 (*see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §20.3*). 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, §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.).

## **40 - Physician Certification and Recertification of Extended Care Services** *(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)*

Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.

The SNF must obtain and retain the required certification and recertification statements. The A/B MAC (A) may request them to assist in determining medical necessity when necessary. The SNF will determine how to obtain the required certification and recertification statements. There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met. Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

If the SNF's failure to obtain a certification or recertification is not due to a question of the necessity for the services, but to the physician's or physician extender's refusal to certify on other grounds (e.g., an objection in principle to the concept of certification and recertification), the SNF cannot charge the beneficiary for covered items or services. Its provider agreement precludes it from doing so.

If a physician or physician extender refuses to certify, because, in his/her opinion, the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing

condition), the services are not covered and the facility can bill the patient directly. The reason for the refusal to make the certification must be documented in the SNF's records.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable (*see Pub.100-04, Medicare Claims Processing Manual, Chapter 6, §120.2, regarding the circumstances under which a resumption of SNF care following a temporary break in SNF coverage would be considered a new "admission" under the SNF PPS's interrupted stay policy*). The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.

In addition, only physicians may certify outpatient physical therapy and outpatient speech-language pathology services.

# Medicare Benefit Policy Manual

## Chapter 15 – Covered Medical and Other Health Services

### 110.1 - Definition of Durable Medical Equipment

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

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 DME MACs 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 DME MAC 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 DME MAC or A/B MAC (A) 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 individuals with intellectual disabilities (ICF/IID)). However, an institution may not be considered a beneficiary’s home if it:

- Meets at least the basic requirement (*see §1861(e)(1) of the Social Security Act (the Act)*) 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 (*see §1819(a)(1) of the Act*) 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 (*see §§1861(s)(6) and 1861(n) of the Act, the implementing regulations at 42 CFR 410.38(b), and §2160B in the State Operations Manual (SOM, Pub. 100-07), Chapter 2*).

*As indicated in §2164 of the SOM, Chapter 2, all hospitals and SNFs that are Medicare-certified are automatically considered to meet the basic requirement described in the applicable bullet above by reason of the Medicare certification itself. Moreover, even an institution (or portion of an institution) that is not certified for Medicare is precluded from being considered a patient's home in this context if it meets either of these basic requirements. See §2166 of the SOM, Chapter 2, for the administrative criteria used in determining whether the basic requirement in the "SNF" definition is met by a nursing home that is not Medicare-certified (including the non-Medicare portion of an institution that also contains a Medicare-certified distinct part SNF).*

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.