HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
220.4 – 220.5	2-25 – 2-26 (2 pp.)	2-25 – 2-26 (2 pp.)
515.1 (Cont.) – 515.2	5-10.1 – 5-10.2 (2 pp.)	5-10.1 – 5-10.2 (2 pp.)

Section 220.3, Recertification, is corrected to change an error in the original Transmittal 368, which is now deleted. The change will continue to allow physicians to sign an initial certification and one more recertification at the same time.

Section 515.1,Coverage and Patient Classification, is being corrected to show that beneficiaries in skilled nursing homes are limited to 100 days of coverage. Therefore, the 90-day Medicare assessment for days 80-89 for the assessment window would pay a maximum of 10 authorized covered days. The applicable Medicare Payment Days would be 91 through 100. This transmittal is also including the grace periods for the other assessment days from day 14 through 100.

CORRECTED MATERIAL--EFFECTIVE DATE: **April 12, 2002.**
***IMPLEMENTATION DATE*: April 12, 2002.**

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 an SNF, and 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 examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see §264) and outpatient physical therapy and outpatient speech pathology services. (See §271.1.)

220.3 Recertification.--The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

A certification may be mailed, faxed or completed when the physician is onsite.

If the circumstances require it, the first recertification must state that the continued need for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

Where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the utilization review (UR) plan, a separate recertification statement is not required. It is sufficient if the records of the UR committee show consideration was given to the recertification content standards. See §251B for requirements regarding certification for presumed coverage cases.

220.4 Timing of Recertifications.--The first recertification must be made no later than the 14th day of inpatient extended care services. An SNF can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical

categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the UR committee and the SNF.

At the option of the SNF, review of a stay of extended duration, pursuant to the facility's utilization review plan, may take the place of the second and any subsequent physician recertifications. The SNF should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the UR committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

220.5 Delayed Certifications and Recertifications.--SNFs are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

220.6 Disposition of Certification and Recertification Statements.--Except for "presumed coverage" cases (see §250), skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary or the Centers for Medicare and Medicaid Services (CMS). Instead, they must be maintained in the SNF medical record.

Extended Care Services Covered Under Hospital Insurance

230. COVERED EXTENDED CARE SERVICES

A. Payment for Extended Care Services.--Patients covered under hospital insurance are entitled to have payment made on their behalf for covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement. Effective with the start of the first cost reporting period on or after July 1, 1998, inpatient SNF services are paid under a prospective payment system. (See §211.) If the items or

- Certain services involving chemotherapy and its administration,
- Radioisotope services,
- Certain customized prosthetic devices,

The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those for electrocardiogram test services furnished during 1998.

In addition, certain services are excluded from the SNF PPS only when furnished on an outpatient basis by a hospital or a CAH:

- 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,
- Lymphatic and venous procedures,
- Ambulance services that convey a beneficiary to a facility to receive any of the previously mentioned excluded outpatient hospital services,

The SNF PPS incorporates adjustments to account for facility case mix, using the system for classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG-III). Facilities will utilize information from the most recent version of the Resident Assessment Instrument (RAI), to classify residents into the RUG-III groups. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare payment (see Medicare Assessment Schedule chart below). The software programs used by providers to assign patients to appropriate RUG-III groups based on the MDS 2.0, called groupers, are available from many software vendors. A grouper can also be accessed directly by providers from CMS's Internet web site at: http://www.hcfa.gov/medicaid/mds20/raven.htm. Other software and data related to SNF PPS can also be accessed on CMS's web site at: www.hcfa.gov/medicaid/mds20/mdssoftw.htm.

For Medicare billing purposes, there is a payment code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities will send each beneficiary's MDS assessment to the State and claims for Medicare payment to the intermediary on a 30-day cycle.

When the initial Medicare-required, 5-day assessment results in a beneficiary being correctly assigned to one of the highest 26 of the 44 RUG-III groups, this effectively creates a presumption of coverage for the beneficiary from admission up to, and including, the assessment reference date for that assessment. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

For a beneficiary assigned to one of these upper 26 groups, the required initial certification essentially serves to verify the correctness of the beneficiary's assignment to that particular RUG-III group. RUG-III hierarchy categories that qualify for the administrative presumption of coverage in connection with the initial Medicare-required, 5-day assessment (assuming services provided are reasonable and necessary) include:

1. Rehabilitation;

2 Extensive care;

3. Special care; or

4. Clinically complex

For a beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups on the initial, Medicare-required, 5-day assessment (or for any beneficiary on a subsequent assessment), the beneficiary is not automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

MEDICARE ASSESSMENT SCHEDULE

Medicare MDS Assessment Type	Assessment Window (including authorized grace days)	Maximum Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 day	Days 1 - 8*	14	1 through 14
14 day	Days 11 - 14	16	15 through 30
30 day	Days 21 - 29	30	31 through 60
60 day	Days 50 - 59	30	61 through 90
90 day	Days 80 - 89	10	91 through 100

*If a patient expires or transfers to another facility before the 5 day assessment is completed, the facility must still prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

515.2 Payment Provisions.--Section 1888(e) of the BBA of 1997 provides the basis for the establishment of the per diem Federal payment rates applied under PPS to SNFs that received their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNFs who first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and the methodology for updating the rates in future years. For the initial period of the PPS beginning on July 1, 1998, and ending on September 30, 1999, all payment rates and associated rules were published in the ***Federal Register*** on May 12, 1998, (63 FR 26252). For each succeeding fiscal year, the rates are to be published in the ***Federal Register*** before August 1 of the year preceding the affected fiscal year.

At the inception of the SNF PPS, providers that were enrolled in the Multi-State Case Mix and Quality Demonstration had the option of remaining in the demonstration until the end of their current fiscal year. Providers with fiscal years that ended on June 30, 1998, converted to PPS payment on the first day of their fiscal year beginning with the cost reporting year July 1, 1998, with all providers having transitioned by June 30, 1999.

The Federal rate incorporates adjustments to account for facility case mix using Resource Utilization Groups Version III (RUG-III), the patient classification system used under the national PPS. RUG-III, is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used both for standardization of the Federal rates and subsequently to establish case-mix adjustments to the rates for patients with different service use.