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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)

MLN Matters Number: MM12009

Related Change Request (CR) Number: 12009

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Effective Date: November 8, 2021

Related CR Transmittal Number: R10880GI, R10880BP, and R10880CP

Implementation Date: November 8, 2021

Provider Types Affected

This MLN Matters Article is for SNFs billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

This article explains the updates to the Medicare General Information, Eligibility, and Entitlement, Pub. 100-01, Medicare Benefit Policy Manual, Pub. 100-02, and Medicare Claims Processing Manual, Pub. 100-04, regarding SNFs. These changes clarify existing content. No policy, processing, or system changes are anticipated. Make sure your billing staff is aware of these updates.

Background

Here are the updates to the following Medicare manuals to correct various minor technical errors and omissions. There are no policy changes. The relevant Manual sections are attached to this CR.

Pub 100-01, Chapter 3, Section 10.4.3:

CMS revised this section by adding clarifying language and appropriate cross-references regarding the type of institution that can serve to prolong a benefit period.

Pub 100-01, Chapter 3, Section 10.4.3.2:

We revised this section by adding clarifying language and appropriate cross-references regarding the type of institution that can serve to prolong a benefit period.

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Pub. 100-02, Chapter 8, Section 20.1:

We revised this section by adding appropriate cross-references.

Pub. 100-02, Chapter 8, Section 40:

We revised this section by adding an appropriate cross-reference.

Pub 100-02, Chapter 15, Section 110.1:

We revised paragraph D of this section by adding clarifying language and appropriate cross references regarding the type of institution that can't qualify as a patient's "home" for purposes of Part B coverage of durable medical equipment (DME).

Pub. 100-04, Chapter 6, Section 10.4.1:

We revised the first paragraph of this section to clarify the language on arrangements.

Pub. 100-04, Chapter 6, Section 20.3.1:

We revised this section by adding a subheading and clarifying the language.

Pub. 100-04, Chapter 6, Section 30:

We revised this section by adding cross-references as appropriate to the instructions on the SNF Prospective Payment System's (PPS) Payment-Driven Payment Model (PDPM) that appear at the end of the chapter.

Pub. 100-04, Chapter 6, Section 30.1:

We revised this section by adding a cross-reference to the PDPM instructions that appear at the end of the chapter.

Pub. 100-04, Chapter 6, Section 30.4.2:

We revised this section by adding a cross-reference to the PDPM instructions that appear at the end of the chapter, and replacing dashes with bullet points for consistency.

Pub. 100-04, Chapter 6, Section 30.5:

We updated this section to reflect the SNF PPS' changeover, as of October 1, 2019, from its previous Resource Utilization Group (RUG) case-mix model to the PDPM. The revised section also includes an expanded list of components of the unadjusted Federal rates for both Rural and Urban areas used by the SNF Pricer.

Pub. 100-04, Chapter 6, Section 50.4:

We revised this section by adding a cross-reference to the PDPM instructions that appear at the end of the chapter.

Pub. 100-04, Chapter 6, Section 120.2:

We revised this section to clarify the language regarding the endpoint of the interruption window under the PDPM's interrupted stay policy. Specifically, if the patient physically leaves the SNF, the first day of the interruption window would be the day of departure itself, whereas if the patient simply discontinues Part A coverage but remains in the SNF, the first day of the interruption window would be the day following the final day of Part A coverage.

Specifying the endpoint of the interruption window's third day as occurring at 11:59 pm rather than at midnight is consistent with the regulations at 42 CFR 411.15(p)(3)(iv), which define a beneficiary's SNF "resident" status for consolidated billing purposes as ending whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF ". . . before the following midnight." See Section 10.1 of this chapter, and also see Section 20.1 in the Medicare Benefit Policy Manual, Chapter 3, which specifies that in counting inpatient days, ". . . a day begins at midnight and ends 24 hours later." However, unlike similar interrupted stay policies under some of the other prospective payment systems, the SNF interrupted stay policy is not used in determining whether bundling would apply to services furnished during the interruption. That determination would instead continue to follow the longstanding set of rules under 42 CFR 411.15(p)(3) regarding SNF "resident" status for consolidated billing purposes.

Pub. 100-04, Chapter 7, Section 10:

We revised this section to correct an erroneous cross-reference (and a typographical error that appears in subsection A), and to revise language in subsection C on the use of bill type 22x by clarifying that, for an SNF's Part A resident, this bill type is used specifically for the resident's screening and preventive services.

Pub. 100-04, Chapter 25, Section 75.5:

We revised this section's discussion of Form Locator (FL) 44 by adding cross-references as appropriate to the PDPM instructions that appear at the end of Chapter 6 of this manual.

More Information

The official instruction, CR 12009, issued to your MAC regarding this change, consists of 3 transmittals. The first transmittal updates Pub 100-01. The second transmittal updates Pub 100-02 and the third updates Pub 100-04.

For more information, contact your MAC.

Document History

Date of Change	Description
August 9, 2021	Initial article released.