



## Medicare Critical Access Hospital Version

### KEY CONCEPTS OUTLINE

#### Module 12: Coverage, Notices, and Billing for Swing Bed Admissions

##### I. Definition of a Swing Bed

- A. The Social Security Act permits certain small, rural hospitals, including a CAH, to enter into an agreement with the Centers for Medicare & Medicaid Services (CMS) that allows a hospital to use its beds to provide either acute care or skilled care when certain criteria are met. <Social Security Act § 1883, 42 C.F.R. § 485.645>
  1. When a hospital is permitted to provide extended care services that would normally be furnished in a Skilled Nursing Facility (SNF), the services are referred to as "swing bed" services.
    - a. The patient "swings" from receiving inpatient acute care services and related reimbursement to receiving SNF services and related reimbursement.
    - b. A swing bed does not need to be located in a special section of the CAH. The patient does not need to change locations or beds in the facility when the patient status changes from acute to swing, unless the CAH requires it. <State Operations Manual, Appendix W § 485.645>
  2. A CAH must be certified by CMS and the State under the Medicare *Conditions of Participation* for Critical Access Hospitals and Swing Beds in CAHs to receive approval for swing bed use. <State Operations Manual, Appendix W § 485.645>

*Swing bed certification is limited to the CAH itself and does not include any rehabilitation or psychiatric distinct part units (DPUs). Swing bed services may not be provided in a CAH's DPU.*

3. A CAH that has been certified for swing beds must be substantially in compliance with SNF requirements including, but not limited to:
  - a. Resident rights;

- b. Admission, discharge and transfer rights and discharge planning;
- c. Patient activities, social services, specialized rehabilitative services and dental services. <42 C.F.R. § 483 Subpart B; 42 C.F.R. § 485.645(d)>

## II. Swing Bed Coverage Requirements

### A. Preceding Inpatient Hospitalization Requirement

1. The patient must have been an inpatient in an acute care hospital for a minimum of three consecutive days (three midnights) within the 30 days prior to the swing bed admission. <42 C.F.R. 409.30(a)(1); see *Medicare Benefit Policy Manual*, Chapter 8 § 20.1>

*Types of hospitals that are appropriate for consideration of a preceding inpatient hospitalization include:*

- Acute care PPS hospital or a CAH;
- Inpatient psychiatric or rehabilitation hospital; or
- Long term acute care hospital.

- a. 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. <See *Medicare Benefit Policy Manual*, Chapter 8 § 20.1>
  - i. The CAH must report OSC 70 which indicates the dates of service of the prior acute care qualifying stay.
  - ii. 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 three-day qualifying hospital stay. <See *Medicare Benefit Policy Manual*, Chapter 8 § 20.1>
- b. A patient is deemed not to have been “discharged” from a swing bed if the time between a prior swing bed discharge and readmission to the same or another swing bed is within 30 days of each other. <*Medicare Claims Processing Manual*, Chapter 6 § 40.3.2>
  - i. In addition to reporting OSC 70, the CAH must also report condition code 57 on the claim to indicate the patient previously received Medicare covered SNF care within 30 days of the current swing bed admission.
  - ii. If more than 30 days has elapsed after the patient’s discharge from a swing bed, the patient must meet the three-day hospital stay requirement again to become eligible for swing bed benefits, unless an exception is met. <*Medicare Claims Processing Manual*, Chapter 6 § 40.3.2>

c. Exception to admission within the 30-day period

- i. An elapsed period of more than 30 days is permitted for swing bed admissions only when the following criteria have been met. <See *Medicare Benefit Policy Manual*, Chapter 8 §§ 20.2.1, 20.2.2>
  - a) The patient's condition makes it medically inappropriate to begin an active course of treatment in a swing bed immediately after hospital discharge; and,
  - b) It is medically predictable at the time of the hospital discharge that the patient will require covered care within a pre-determined period (i.e., within 45 days of discharge).

**Example:** Under the established standard of care for the treatment of a hip fracture it is known that skilled therapy services will be required after hospital care. Therapy services normally begin within four to six weeks after hospital discharge, when weight bearing can be tolerated, and skilled therapy services can only be provided on an inpatient basis.

- c) The CAH must report condition code 56 on the claim to indicate the patient's swing bed admission was appropriately delayed more than 30 days after acute care discharge because the patient's condition made it inappropriate to begin care within the 30-day period.
- d) The CAH must report OSC 70 to indicate the dates of service of the prior acute care qualifying stay.

B. Skilled Level of Care Requirement

1. General requirements

- a. Skilled nursing and/or skilled rehabilitation services provided in a CAH's swing bed must:
  - i. Be ordered by a physician for an identifiable skilled need; <42 *C.F.R.* 409.31(a)(1)>
  - ii. Require the skills of licensed, non-physician professionals such as a registered nurse (RN), physical therapist (PT), occupational therapist (OT) or speech language pathologist (SLP); and, <42 *C.F.R.* 409.31(a)(2)>

- iii. Be provided directly by or under the supervision of a licensed RN, PT, OT or SLP. <42 C.F.R. 409.31(a)(3)>
- b. The skilled nursing and/or skilled rehabilitation services must be furnished for:

- i. A condition that the patient received inpatient hospital services for. <42 C.F.R. 409.31(b)(2)(i); see *Medicare Benefit Policy Manual*, Chapter 8 § 20.1>

*The condition that qualifies the patient for skilled care can be the principal diagnosis that caused the patient's admission to the hospital or it could be any of the conditions present during the qualifying hospital stay.*

- ii. A different condition which develops during the swing bed stay in addition to a condition that the patient had received inpatient hospital services for. <42 C.F.R. 409.31(b)(2)(ii); see *Medicare Benefit Policy Manual*, Chapter 8 § 20.1>

## 2. Skilled services defined

- a. A service is considered to be skilled if it can only be performed safely and/or effectively by or under the general supervision of skilled nursing or rehabilitation staff on an inpatient basis. <42 C.F.R. 409.31(b)(3); see *Medicare Benefit Policy Manual*, Chapter 8 §§ 30.2.1, 30.2.2>
  - i. Skilled services may be necessary to improve, maintain, or prevent further deterioration of the patient's condition.
- b. The patient's medical condition, diagnosis, or prognosis should not be the sole factor in deciding if skilled services are needed. <See *Medicare Benefit Policy Manual*, Chapter 8 §§ 30.2.2, 30.2.4>
  - i. A service that is ordinarily considered to be non-skilled could be skilled based on the patient's medical complications which require nursing or rehabilitation staff to perform or observe the service.

*Documentation of the complications and the need for special services must be supported by a physician's order and nursing and rehabilitation progress notes.*

## 3. Daily basis defined

- a. The patient must require skilled nursing or a combination of skilled nursing and skilled rehabilitation services daily. <42 C.F.R. 409.31(b)(1); 42 C.F.R. 409.34>

- i. To meet the daily basis requirement, skilled services must be needed and provided seven days a week. <See *Medicare Benefit Policy Manual*, Chapter 8 § 30.6>

*The daily 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.*

- ii. Exceptions to the daily requirement

- a) Skilled rehabilitation only

- 1) If a patient's swing bed admission is based solely on the need for skilled rehabilitation services, the daily requirement would be met if the patient needed and received skilled rehabilitation services at least five days a week. <See *Medicare Benefit Policy Manual*, Chapter 8 § 30.6>

- a. The daily requirement is not met if all therapy sessions can be provided on one day but are scheduled so that some therapy is furnished each day, unless the patient's medical needs indicate such scheduling.

*Example: If physical therapy is furnished on three days each week and occupational therapy is furnished on two different days of the same week, the "daily basis" requirement would only be satisfied if there is a valid medical reason why both types of therapy cannot be furnished on the same day.*

- b. A break of one or two days of skilled rehabilitation services will not prevent coverage of the swing bed admission if discharging the patient for that period would not be practical. This may occur when the physician has suspended the therapy sessions because the patient exhibits extreme fatigue.

- b) Restorative nursing

- 1) When a patient requires skilled restorative nursing, the service must be provided at least six days per week. <See *Medicare Benefit Policy Manual*, Chapter 8 § 30.6>

*In general, restorative nursing is a program that helps a patient maintain any progress that has been made during therapy services and enables the patient to continue to function at a higher level.*

- a. A restorative nursing program is usually developed by a therapist when it is expected to be only a few weeks in duration. Documentation in the medical record must clearly justify the services ordered.

### III. Swing Bed Documentation

#### A. Certification and Recertification Requirement

1. Payment for swing bed services may be made under Medicare Part A only if a physician, or NPP working in collaboration with a physician, makes the required certification and, where applicable, the required recertification for the services that are furnished. <See 42 C.F.R. 424.20; *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 §§ 40-40.6>
2. Certification timing, form, and content

##### a. Certification timing

- i. The certification must be obtained at the time of admission, or as soon as is "reasonable and practicable". <*Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 40.2>

*Completion of a facility's routine admission procedure by the physician or NPP is not sufficient for the certification of the necessity for swing bed services.*

##### b. Certification form

- i. There is no requirement that a specific form must be used. Certification statements may be included in a separate form, notes, or other documents that would normally be signed in caring for the patient. <*Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 40.1; *Medicare Program Integrity Manual*, Chapter 6 § 6.3>

*Each certification and recertification statement, if applicable, must be signed separately by the attending physician or NPP who has knowledge of the case. The certification and recertification statements must be kept in the medical record and available for verification by the MAC, as requested.*

##### c. Certification content

- i. The certification must clearly indicate that swing bed services were required to be given on an inpatient basis because of the patient's need for skilled care on a continuing basis for any of the conditions that the patient received

inpatient hospital care. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40.2>

### 3. Recertification timing, form, and content

#### a. Recertification timing

- i. The first recertification must be made no later than the 14<sup>th</sup> day of the swing bed stay. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40.4>
  - a) The facility can require that the first recertification by the physician be made earlier or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.
  - b) A subsequent recertification must be made at intervals not to exceed 30 days.
    - 1) A subsequent recertification may be made at shorter intervals as established by the facility's utilization review committee.
    - 2) If a facility has a utilization review plan in place for swing bed services, the review of a stay of extended duration may take the place of the second and any subsequent physician recertification.

*The facility should have available a written description of its procedure that describes the intervals at which a recertification is required and states that the review by the utilization review committee serves as an alternative to a recertification by a physician for the second or subsequent recertification.*

#### b. Recertification form

- i. There is no requirement that a specific form must be used. A recertification statement may be included in a separate form, notes, or other documents that would normally be signed by the attending physician or NPP who has knowledge of the case and is caring for the patient. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40.1; Medicare Program Integrity Manual, Chapter 6 § 6.3>

#### c. Recertification content

- i. When an initial or subsequent recertification is required, it must state that the continued need for swing bed services is for a condition for which the patient received inpatient hospital services or for a condition that arose during the swing bed stay after the transfer from the inpatient hospital.

< Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40.3 >

- ii. The recertification statement must contain the reason(s) for the continued need for swing bed services, the estimated time required for the patient to remain in the facility, and any plans for home care, if appropriate.

*If all required information is already included in other medical record documentation (e.g., progress notes), the physician does not have to include all components in a single recertification statement.*

## B. Absence of Certification or Recertification

### 1. Failure to obtain certification or recertification

#### a. Skilled care deemed not medically necessary

- i. If a physician or NPP refuses to certify or recertify a swing bed stay because the patient does not require daily skilled services for an ongoing condition for which the patient received inpatient hospital services or for ongoing treatment of a new condition that arose while in the swing bed, the services are not covered. < Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40 >
  - a) The reason for the refusal to make the certification or recertification must be clearly documented in the medical record and must be signed by the attending physician, NPP, or responsible facility official.
  - b) The facility must issue a liability notice to Medicare patients before the facility provides an item or service that is not considered to be medically necessary or the service is considered to be custodial care. < Medicare Claims Processing Manual, Chapter 30 §§ 70-70.2 >
    - 1) The revised SNFABN replaces the prior five SNF denial letters and Notice of Exclusion from Medicare Benefits (NEMB-SNF) form.
    - 2) Handout 20 is a copy of the form and the instructions.

**Link: Beneficiary Notices Initiative under Medicare Related Sites – General**  
Use the FFS SNFABN button on the left navigation bar.

- 3) SNFs must use the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, when billing items and services that are

considered to be not medically necessary under Part B (i.e., TOB 0121). The ABN form was discussed in a prior module.

**Link: Beneficiary Notices Initiative under Medicare Related Sites – General**  
Use the FFS ABN button on the left navigation bar.

- b. Failure to obtain for other reasons
  - i. If the facility's failure to obtain a certification or recertification is because the physician or NPP refuses to certify based on other grounds (e.g., an objection to completing the necessary certification and/or recertification documentation), the facility may not bill Medicare or the beneficiary for the covered services. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40>
- 2. Delay in obtaining timely certification and/or recertification
  - a. A facility is required to obtain timely certification and recertification statements. However, a delayed certification and/or recertification may be honored when an isolated oversight or lapse in time occurs. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4 § 40.5>
  - i. In addition to complying with the content requirements above, a delayed certification and/or recertification must include an explanation for the delay, including any medical or other related evidence that may be relevant for purposes of explaining the delay.

*The facility may determine the format of the delayed certification and/or recertification statements. The explanation for the entire delay may appear in one statement. A separate signed statement for each delayed certification and recertification is not required.*

### C. Medical Record Documentation

1. To support medical necessity of the swing bed admission, documentation must substantiate the patient's need for skilled level of services in a swing bed and the patient's response to those services. < *State Operations Manual*, Appendix W § 485.645; see *Medicare Benefit Policy Manual*, Chapter 8 § 30.2.2 >

#### *Documentation elements*

- *Must be consistent with the nature and severity of the patient's illness or injury, specific medical needs, and accepted standards of medical practice*
- *Must show that the services are appropriate in duration and quantity*
- *Must show that the services promote the ordered therapeutic goals*
- *May be in an electronic and/or paper format*
- *Medicare does not require a CAH to use the Minimum Data Set (MDS) form for recording the patient assessment or for nursing care planning; however, the MDS may be used as a clinical documentation tool*

2. If the patient remains in the CAH or transfers into the CAH's swing bed from another facility, the medical record must include:
  - a. Discharge orders from the acute care hospital or CAH;
  - b. Admissions orders to the swing bed; and,
  - c. Progress notes, as appropriate. < *State Operations Manual*, Appendix W § 485.645 >
    - i. If the patient remains in the CAH for swing bed services after the acute care stay, the same chart can be used only if the swing bed section of the chart is separate and includes the appropriate admission orders, progress notes and supporting documents.

#### D. Length of Stay

1. There is no length of stay restriction for a swing bed patient in a CAH. <State Operations Manual, Appendix W § 485.645>
2. A CAH is not required by Medicare to place a swing bed patient in a nursing home or have a transfer agreement between the CAH and nursing home; however, state laws may vary. <State Operations Manual, Appendix W § 485.645>

*While there is no length of stay limit for swing bed patients, the intended use for a swing bed is to allow the patient to fully recover and return home or while awaiting placement into a nursing facility. The CAH should document in the patient's medical record efforts made for nursing facility placement.*

#### IV. Professional Services During a Swing Bed Admission

##### A. Federally Mandated Visits

1. Initial comprehensive visit
  - a. The federally mandated initial comprehensive visit must be performed by a physician or qualified NPP operating under his or her scope of practice and state law. <See Medicare Claims Processing Manual, Chapter 12 § 30.6.13>
  - b. The initial visit must occur no later than 30 days after admission.
  - c. Documentation must include a thorough assessment of the patient, development of a plan of care, and a written, signed order for skilled services.
2. Subsequent visits
  - a. Medicare Part B will cover other federally mandated visits to monitor and evaluate patients:
    - i. At least once every 30 days for the first 90 days after admission; and,
    - ii. At least once every 60 days thereafter for the remainder of the covered swing bed stay. <See Medicare Claims Processing Manual, Chapter 12 § 30.6.13>
3. Federally mandated professional visits must be in person and may not be delivered via telehealth. <Medicare Claims Processing Manual Transmittal 10716>

##### B. Other Medically Necessary Visits

1. Medically necessary visits by a physician or qualified NPP performed prior to or after the federally mandated visits may be covered for the diagnosis or treatment of an illness or injury. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13>
  - a. Payment is made for visits to patients in a swing bed only when the visits are reasonable and medically necessary as documented in the medical record.
  - b. The Nursing Facility Services CPT codes represent a “per day” service. Medicare will not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.

**Caution:** Medicare does not pay for additional E/M visits that may be required by state law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.

- C. Telehealth Visits <*Medicare Claims Processing Manual* Transmittal 10716; MLN Matters 12068>
  1. Medicare pays for medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when
    - a. Provided by a physician/NPP whose opinion or advice on a specific problem is requested by another physician/NPP or other appropriate source
    - b. Documented by the consultant in in the medical record, and
    - c. The consultant provides a written report to the referring physician/NPP
  2. Payment for subsequent hospital or nursing care services (non-consultative) is limited to
    - a. One subsequent hospital telehealth visit every 3 days
    - b. One nursing facility telehealth visit every 30 days for dates of service prior to January 1, 2021
      - i. Beginning with dates of service on/after January 1, 2021, one telehealth visit every 14 days
  3. Telehealth limitations do not apply to consultation services.

## V. Billing for Swing Bed Services

### A. Type of Bill (TOB)

1. Swing bed services provided in a CAH are billed on TOB 018X. < *Official UB-04 Data Specifications Manual* >

*In most circumstances, the same revenue codes for ancillary services (e.g., radiology, laboratory, and drugs) that are reported for an acute inpatient stay may be reported on the swing bed claim.*

### B. Inpatient Part B Benefit

1. The swing bed setting does not include an inpatient Part B benefit. For patients who continue to receive extended care services after the end of a covered Part A stay (e.g., benefits exhausted or not receiving a skilled level of care, etc.), ancillary services may be billed under the hospital benefit as inpatient Part B services. < *Medicare Claims Processing Manual, Chapter 6, §100* >
  - a. A patient in a swing bed cannot simultaneously receive coverage for both SNF-level services under Part A (TOB 018X) and inpatient hospital ancillary services under Part B (TOB 012X).
2. The hospital may submit a claim to the MAC for those inpatient services covered by Part B using TOB 012X. The beneficiary would be eligible for the same benefits available to a hospital inpatient in a Part B stay when benefits have been exhausted. < *Medicare Claims Processing Manual, Chapter 6, §100* >

- *For a list of services that may be reported on a 012X claim, see the Medicare Benefit Policy Manual, Chapter 6 § 10.2, discussed in a previous module.*
- *For a list of services by revenue codes that are not payable and may not be reported on a 012X claim, see the Medicare Claims Processing Manual, Chapter 4 § 240.2, discussed in a previous module.*

3. In addition to billing for services under the inpatient Part B benefit, the CAH must also file a monthly Part A non-covered claim on a TOB 0180 using the appropriate nonpayment condition code (i.e., condition code 21). < *Medicare Claims Processing Manual, Chapter 6 §100* >

### C. Medicare Advantage Plan Swing Bed Claims

1. When a patient's swing bed services are covered under a Medicare Advantage Plan, the stay must also be reported on an informational claim to the MAC to count the number of days paid by the plan. < *Medicare Claims Processing Manual, Chapter 6 § 90.2* >

- a. Part A days paid by the plan are part of a patient's 100 days of Medicare SNF benefits. The MAC will subtract the benefit days from the Common Working File to accurately show the benefit days available.
- b. The claim must be submitted to the MAC using TOB 018X reporting covered room and board charges and condition code 04 to indicate to the MAC that the claim is informational only.

## VI. Payment for Swing Bed Services

### A. Payment in General

1. Payment for swing bed services in a CAH will only be made for covered post-hospital extended care services if those services would normally have been furnished by a SNF. <Social Security Act § 1861(h); 42 C.F.R. § 485.645>
  - a. These services include nursing care, room and board, medical social services, rehabilitation services, and drugs.

*Although a CAH is reimbursed for providing a skilled level of care that would normally be provided in a SNF, a swing bed patient is considered to be a patient of the hospital and the Medicare Conditions of Participation for Critical Access Hospitals apply.*

### B. Differences in Swing Bed Payment Methodologies

1. SNF Prospective Payment System (PPS)
  - a. Rural hospitals, with less than 100 beds, that are paid under the PPS methodology, may be certified under CMS to provide swing bed services. The swing bed services will be paid under the SNF PPS. <42 C.F.R. § 482.58; 42 C.F.R. § 413.114(a)(2); 42 C.F.R. § 483.20>

*When swing bed services are paid under SNF PPS, the hospital must complete the Minimum Data Set (MDS) patient assessment at prescribed timeframes and services are paid under the Patient Driven Payment Model (PDPM).*

### 2. SNF Consolidated Billing

- a. Under SNF PPS, all covered Part A services that are within the scope and capability of the SNF are paid in the PPS rate. In certain circumstances, the SNF must obtain services from other providers. <See Medicare Claims Processing Manual, Chapter 6 §§ 10.1. 10.2>
  - i. Neither the SNF nor another facility or practitioner may bill the services under Part B, unless the services are specifically excluded from PPS.

- ii. This concept is referred to as consolidated billing. It applies to SNFs and hospitals (i.e., short term, long term, and rehabilitation) with certified swing beds paid under the SNF PPS.
  - a) The consolidated billing concept does not apply to certified swing beds in a CAH (discussed in detail later in this module).
- iii. The limited services that are excluded from the SNF Part A payment may be billed separately by the facility and/or the practitioner who performs the service. <See *Medicare Claims Processing Manual*, Chapter 6 §§ 10.1, 10.2>
  - a) The excluded services, such as surgical services and certain imaging services that are outside of the scope and capability of a SNF, are found in the annual update to the SNF consolidated billing file. <See *Medicare Claims Processing Manual*, Chapter 6 §§ 10.2, 20.1, 100, 100.1>

**Link: SNF Consolidated Billing – Overview Page under Medicare Related Sites – Post-Acute Care**

Use the Part A button on the left navigation bar for the appropriate year. For example, for 2023, use the **2023 Part A MAC Update** button.

**Link: SNF Consolidated Billing – Overview Page under Medicare Related Sites – Post-Acute Care**

See Downloads section for an explanation of the major categories

**Caution:** The General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing document **does not** apply to CAHs.

### 3. Cost-based Reimbursement

- a. Under the Benefits Improvement and Protection Act (BIPA) of 2000, a CAH is exempt from the SNF PPS. A CAH is paid 101% of its reasonable costs for providing covered swing bed services. <*Social Security Act* §1888(e)(7)(C); 42 *C.F.R.* § 413.114(a)(2); 42 *C.F.R.* 413.70>
  - i. Under the principles of reimbursement, a CAH must report its costs on an annual cost report for its fiscal year. <42 *C.F.R.* 413.70; 42 *C.F.R.* 413.20>
  - ii. The cost report is used to determine the Medicare swing bed rate per patient day (i.e., interim rate) for routine services based on the previous year's costs of providing covered services. <42 *C.F.R.* § 413.114>
    - a) The interim rate is used for the current cost reporting period.

### 4. Hospital Bundling Requirements

- a. CAH swing bed services are subject to hospital bundling requirements. All services provided to a CAH's swing bed patient must be included on the CAH's swing bed claim using TOB 18X. <Social Security Act § 1862(a)(14); 42 C.F.R. § 411.15(m); see Medicare Benefit Policy Manual, Chapter 6 § 100.1; see email response from CMS case number 2016-85040>
  - i. While the patient is in a covered swing bed stay, the CAH should not separately bill for hospital outpatient ancillary services (i.e., an MRI or surgery on TOB 0851).
  - ii. A patient in a covered Part A swing bed stay is **not** responsible for Part B deductible and coinsurance.

#### 5. Application of CRNA Pass-Through Exemption

- a. The CRNA pass-through exemption applies to hospital outpatient and inpatients (discussed in a prior module). Since a swing bed may be used to provide either acute inpatient care or SNF level of care, the pass-through exemption will apply to procedures that require anesthesia while the patient is in a swing bed. <See Medicare Claims Processing Manual, Chapter 4 § 250.3.3.1 >
  - i. CRNA services provided to CAH swing bed patients under the pass-through exemption must be included on the swing bed claim.

### VII. Calculating Patient Financial Responsibility for Swing Bed Services

#### A. Benefit Period

1. The benefit period begins to run when the patient is first admitted to a hospital or SNF or swing bed for inpatient care. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, § 10.4.1>
  - a. There is no requirement that all care within a benefit period relate to the same physical or mental condition.
2. The benefit period ends when the patient has not been an inpatient of a hospital or SNF (swing bed) for 60 consecutive days (discussed in a previous module). <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, § 10.4.2>
  - a. The day of discharge begins the counting of the 60 consecutive day period.
3. Swing bed coinsurance is billable to the beneficiary after the first 20 days of skilled care in a benefit period. <42 C.F.R. § 409.85>

- a. For each day from the 21<sup>st</sup> through the 100<sup>th</sup> day, the coinsurance amount is 1/8<sup>th</sup> of the current year inpatient hospital deductible. <42 C.F.R. § 409.85>
  - i. For CY 2023, the inpatient hospital deductible is \$1,600 per benefit period. <84 Fed. Reg. 61619>
    - a) For CY 2023, the swing bed coinsurance amount is \$200 per day

### Case Study 1

**Facts:** A patient was admitted to a CAH on January 1, 2023 for complications related to her diabetes. The patient was discharged from acute care on January 4, 2023 and admitted to the CAH's swing bed on the same day. The patient was discharged to home health on February 1, 2023. This is the patient's first admission for SNF level of care in 2023.

- How much will the patient pay for the total deductible and coinsurance amount during the swing bed stay?

**Modified Facts:** During the swing bed stay, the patient began to complain of severe headaches. The physician ordered an MRI of the brain without and with contrast. After review of the exam, the findings were normal, and no additional treatment or skilled services were required.

- Which is the most appropriate method for the CAH to bill for the MRI?
  - a) On an outpatient claim (TOB 0851) because the procedure is listed as one of the Major Categories for SNF Consolidated Billing.
  - b) On the swing bed claim (TOB 181) because a CAH is reimbursed cost for all services provided during the swing bed stay and the patient will not have any outpatient out of pocket expense (i.e., deductible and coinsurance).

## CASE STUDIES WITH ANALYSIS

### Case Study 1

**Facts:** A patient was admitted to a CAH on January 1, 2023 for complications related to her diabetes. The patient was discharged from acute care on January 4, 2023 and admitted to the CAH's swing bed on the same day. The patient was discharged to home health on February 1, 2021. This is the patient's first admission for SNF level of care in 2023.

- How much will the patient pay for the total deductible and coinsurance amount during the swing bed stay?

**Analysis:** \$1,600. The patient would be responsible for 8 days of coinsurance from January 24<sup>th</sup> through January 31<sup>st</sup> at \$200 per day. The first 20 days in the swing bed (January 4<sup>th</sup> through January 23<sup>rd</sup>) are covered under the SNF benefit and the patient does not pay a deductible or coinsurance. For each day from the 21<sup>st</sup> to the 100<sup>th</sup> day of SNF benefits, the patient is responsible for a coinsurance amount that is equal to the 1/8<sup>th</sup> of the current inpatient deductible. The day of admission to the swing bed but not the day of discharge is counted towards the coinsurance.

**Modified Facts:** During the swing bed stay, the patient began to complain of severe headaches. The physician ordered an MRI of the brain without and with contrast. After review of the exam, the findings were normal, and no additional treatment or skilled services were required.

- Which is the most appropriate method for the CAH to bill for the MRI?
  - a) On an outpatient claim (TOB 0851) because the procedure is listed as one of the Major Categories for SNF Consolidated Billing.
  - b) On the swing bed claim (TOB 181) because a CAH is reimbursed cost for all services provided during the swing bed stay and the patient will not have any outpatient out of pocket expense (i.e., deductible and coinsurance).

**Analysis: b)** A CAH is exempt from the SNF PPS and Consolidated Billing rules and the Major Categories for SNF Consolidated Billing does not apply in this setting. Instead, a CAH must follow the hospital bundling regulations. All covered services, including CRNA pass-through services, provided while the patient is in a swing bed must be included on the swing bed claim (TOB 181), regardless of the reason for the service, the findings, or if additional services were required. A patient in a covered swing bed stay in a CAH does not have any

outpatient out of pocket liability. The professional fees for the provider who performed the MRI should be billed separately.

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## 20 - Prior Hospitalization and Transfer Requirements (Rev. 1, 10-01-03)

### A3-3131, SNF-212

In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, effective December 5, 1980, the individual must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in [§20.2](#) applies.

### 20.1 - Three-Day Prior Hospitalization

*(Rev. 261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)*

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, section 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, section 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. 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 Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 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.).

### **20.1.1 - Three-Day Prior Hospitalization - Foreign Hospital**

*(Rev. 261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)*

*Regardless of whether a foreign hospital stay is itself coverable under the heading of "foreign hospital services" (see Pub. 100-04, Medicare Claims Processing Manual, chapter 32, §§350ff. for a description of the foreign hospital services that are payable by Medicare), an inpatient stay of 3 or more days in a hospital outside the United States may*

*nevertheless* satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States *as long as* the foreign hospital *can qualify* as an “emergency hospital” (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, §20.2, for the definition of an emergency services hospital). If a stay of 3 or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the SNF will submit documentation to the A/B MAC (A). This evidence will be either:

- A. An itemized bill or hospital form prepared by the foreign hospital showing dates of admission and discharge and a description of the illness or injury treated (obtained from the beneficiary); or
- B. A medical report prepared by the foreign hospital and sent to the patient’s U.S. physician showing dates of admission and discharge and a description of the illness or injury treated (obtained from the physician).

If neither type of evidence can be obtained, the SNF will secure whatever information is available for submission to the A/B MAC (A). When the A/B MAC (A) receives a bill involving a prior inpatient stay in a foreign hospital, it contacts the regional office for a determination as to whether the prior stay requirement is met. If the regional office states the hospital does not qualify as an “emergency hospital,” the A/B MAC (A) advises the provider that the prior inpatient stay requirement is not met.

If the regional office states the hospital qualifies as an “emergency hospital” and documentation is submitted as outlined in either §20.2.1 or 20.2.2 which otherwise meets the prior-stay requirement, the A/B MAC (A) processes the SNF claim.

## **20.2 - Thirty-Day Transfer (Rev. 1, 10-01-03)**

**A3-3131.3, SNF-212.3**

### **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, such services could not be deemed to be “post-hospital” extended care services. (For exception, see §20.2.2 below.)

## **20.2.2 - Medical Appropriateness Exception** (Rev. 1, 10-01-03)

### **A3-3131.3.B, SNF-212.3.B**

An elapsed period of more than 30 days is permitted for SNF admissions where the patient’s condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

### **20.2.2.1 - Medical Needs Are Predictable** (Rev. 1, 10-01-03)

#### **A3-3131.3.B.1, SNF-212.3.B.1**

In determining the type of case that this exception is designed to address, it is necessary to recognize the intent of the extended care benefit. The extended care benefit covers

relatively short-term care when a patient requires skilled nursing or skilled rehabilitation services as a continuation of treatment begun in the hospital. The requirement that covered extended care services be provided in a SNF within 30 days after hospital discharge is one of the means of assuring that the SNF care is related to the prior hospital care.

This exception to the 30-day requirement recognizes that for certain conditions, SNF care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within 30 days after hospital discharge. Since the exception is intended to apply only where the SNF care constitutes a continuation of care provided in the hospital, it is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame. Accordingly, to qualify for this exception it must be medically predictable at the time of hospital discharge that a covered level of SNF care will be required within a predictable period of time for the treatment of a condition for which hospital care was received and the patient must begin receiving such care within that time frame.

An example of the type of care for which this provision was designed is care for a person with a hip fracture. Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within four to six weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a patient with a hip fracture to a SNF within 4 to 6 weeks after hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by a SNF, would be considered a timely admission.

### **20.2.2.2 - Medical Needs Are Not Predictable** (Rev. 1, 10-01-03)

#### **A3-3131.3.B.2, SNF-212.3.B.2**

When a patient's medical needs and the course of treatment are not predictable at the time of hospital discharge because the exact pattern of care required and the time frame in which it will be required is dependent on the developing nature of the patient's condition, an admission to a SNF more than 30 days after discharge from the hospital is not justified under this exception to the 30-day rule. For example, in some situations the prognosis for a patient diagnosed as having cancer is such that it can reasonably be expected that additional care will be required at some time in the future. However, at the time of discharge from the hospital it is difficult to predict the actual services that will be required, or the time frame in which the care will be needed. Similarly, it is not known in what setting any future necessary services will be required; i.e., whether the patient will require the life-supporting services found only in the hospital setting, the type of care covered in a SNF, the intermittent type of care which can be provided by a home health agency, or custodial care which may be provided either in a nursing home or the patient's

place of residence. In some instances such patients may require care immediately and continuously; others may not require any skilled care for much longer periods, perhaps measured in years. Therefore, since in such cases it is not medically predictable at the time of the hospital discharge that the individual will require covered SNF care within a predeterminable time frame, such cases do not fall within the 30-day exception.

### **20.2.2.3 - SNF Stay Prior to Beginning of Deferred Covered Treatment (Rev. 1, 10-01-03)**

#### **A3-3131.3.B.3, SNF-212.3.B.3**

In some cases where it is medically predictable that a patient will require a covered level of SNF care within a predeterminable time frame, the individual may also have a need for a covered level of SNF care within 30 days of hospital discharge. In such situations, this need for covered SNF care does not negate further coverage at a future date even if there is a noncovered interval of more than 30 days between the two stays, provided all other requirements are met. (See example 1 below.) However, this rule applies only where part of the care required involves deferred care, which was medically predictable at the time of hospital discharge. If the deferred care is not medically predictable at the time of hospital discharge, then coverage may not be extended to include SNF care following an interval of more than 30 days of noncovered care (see example 2). Where it is medically predictable that a patient will require a covered level of SNF care within a specific time frame, the fact that an individual enters a SNF immediately upon discharge from the hospital for noncovered care does not negate coverage at a later date, assuming the requirements of the law are met (see example 3).

#### **EXAMPLE 1:**

A patient who has had an open reduction of a fracture of the femoral neck and has a history of diabetes mellitus and angina pectoris is discharged from the hospital on January 30, 1991 and admitted immediately to a SNF. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his condition or complications resulting from his restricted mobility, which necessitates skilled management of his care to ensure his safety and recovery. It is medically predictable that when he is medically allowed to bear weight on the affected limb, skilled rehabilitative services will be required. After he is in the SNF for two days, he becomes unhappy and at his request is released to his home in the care of a full time private duty nurse. Five weeks later, when he reaches weight bearing, he is readmitted to the SNF for the needed rehabilitative care. The patient would be eligible for coverage under the program for the care furnished him during both of these stays.

#### **EXAMPLE 2:**

An individual is admitted to a SNF for daily skilled rehabilitative care that, as a practical matter, can be provided only on an inpatient basis in a SNF. After three weeks, the

therapy is discontinued because the patient's condition has stabilized and daily skilled services are no longer required. Six weeks later, however, as a result of an unexpected change in the patient's condition, daily skilled services are again required. Since the second period of treatment did not constitute care which was predictable at the time of hospital discharge and thus could not be considered as care which was deferred until medically appropriate, it would not represent an exception to the 30-day exception rule. Therefore, since more than 30 days of noncovered care had elapsed between the last period of covered care and the reinstatement of skilled services, payment could not be made under the extended care benefit for the latter services.

**EXAMPLE 3:**

A patient whose right leg was amputated was discharged from the hospital and admitted directly to a SNF on January 30, 1991. Although upon admission to the SNF the patient required help with meeting his activities of daily living, he did not require daily skilled care. Subsequently, however, after the stump had healed, daily skilled rehabilitative services designed to enable him to use a prosthesis were required. Since at the time of the patient's discharge from the hospital it was medically predictable that covered SNF care would be required at a predeterminable time interval, and since such care was initiated when appropriate, the patient would be entitled to extended care benefits for the period during which such care was provided.

**20.2.2.4 - Effect of Delay in Initiation of Deferred Care  
(Rev. 1, 10-01-03)**

**A3-3131.3.B.4, SNF-212.3.B.4**

As indicated, where the required care commences within the anticipated time frame, the transfer requirement would be considered met even though more than 30 days have elapsed. However, situations may occur where complications necessitate delayed initiation of the required care and treatment beyond the usual anticipated time frame (e.g., skilled rehabilitative services which will enable an amputee patient to use a prosthetic device must be deferred due to an infection in the stump). In such situations, the 30-day transfer requirement may still be met even though care is not started within the usual anticipated time frame, if the care is begun as soon as medically possible and the care at that time is still reasonable and necessary for the treatment of a condition for which the patient received inpatient hospital care.

**20.2.2.5 - Effect on Spell of Illness  
(Rev. 228, Issued: 10-13-16, Effective: 10-18-16, Implementation: 10-18-16)**

In the infrequent situation where the patient has been discharged from the hospital to his or her home more than 60 days before he or she is ready to begin a course of deferred care in a SNF, a new spell of illness begins with the day the beneficiary enters the SNF thereby generating another 100 days of extended care benefits (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, section

10.4.1). Another qualifying hospital stay would not be required, providing the care furnished is clearly related to a hospital stay in the previous spell of illness and represents care for which the need was predicted at the time of discharge from such hospital stay.

### **20.2.3 - Readmission to a SNF**

**(Rev. 242, Issued: 03-16-18, Effective: 06-19-18; Implementation: 06-19-18)**

If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met. The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days after the first day of noncoverage. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage. (See §§20.2.2 and 20.2.2.3 above for situations where a period of more than 30 days between SNF discharge and readmission, or more than 30 days of noncovered care in a SNF, is followed by later covered care.)

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[a] resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that

## Medicare Benefit Policy Manual Chapter 8

### **30.2 - Skilled Nursing and Skilled Rehabilitation Services** (Rev. 1, 10-01-03)

A3-3132.1, SNF-214.1

#### **30.2.1 - Skilled Services Defined** (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

**NOTE:** “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

**30.2.2 - Principles for Determining Whether a Service is Skilled**  
 (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)  
 A3-3132.1.B, SNF-214.1.B

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.
- The intermediary or MAC considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

**EXAMPLE:** When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel. (See §30.5.)

- A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes.

**EXAMPLE:**

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. The documentation needs to support the severity of the circulatory condition that requires skilled care (see section 30.2.2.1).

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in

light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

**EXAMPLE:**

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan. As discussed in section 30.2.2.1 below, the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

**EXAMPLE:**

A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

**30.2.2.1 – Documentation to Support Skilled Care Determinations  
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)**

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and

accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services. By the same token, the **treatment goal itself** cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment from restoration to maintenance. Instead, it would make such a change on a prospective basis only.

Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.

It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no "improvement" to evaluate. For example, when skilled services are necessary to maintain the patient's current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal. Similarly, establishing that a maintenance program's services are reasonable and necessary would involve regularly documenting the degree to which the program's treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness in achieving this goal. When the maintenance program is

**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 be documented 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.

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- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.) (See Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services.”)

### **30.6 - Daily Skilled Services Defined**

*(Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)*

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 be documented 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 *through* 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.

**30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"**  
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)  
A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

**30.6.13 - Nursing Facility Services****(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)****A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments**

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to the Medicare Learning Network article SE0418 at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>

The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier “-AI”, (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C-04-08 (see <http://www.cms.gov/site-search/search-results.html?q=S%26C-04-08>) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), in a SNF the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial federally mandated comprehensive visit in a SNF.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS)), who is not employed by the facility, may perform the initial visit when the State law permits. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure, and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a

non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301- 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

### **Medically Necessary Visits**

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

### **SNF Setting--Place of Service Code 31**

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

### **NF Setting--Place of Service Code 32**

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

**B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF**

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311-99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

A/B MACs (B) shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 - 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

 Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

### **C. Visits by Qualified Nonphysician Practitioners**

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

#### **Medically Necessary Visits**

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

#### **SNF Setting--Place of Service Code 31**

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

#### **NF Setting--Place of Service Code 32**

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 10716</b>	<b>Date: April 6, 2021</b>
	<b>Change Request 12068</b>

**Transmittal 10618, dated March 16, 2021, is being rescinded and replaced by Transmittal 10716, dated, April 6, 2021, to remove MDB from business requirement 12068.2. All other information remains the same.**

**SUBJECT: Common Working File (CWF) Edits for Medicare Telehealth Services and Manual Update**

**I. SUMMARY OF CHANGES:** This Change Request (CR) implements claims frequency editing to be performed by the Common Working File (CWF) based on relevant policy limitations for subsequent nursing facility care services and updates the Claims Processing Manual to reflect this revision.

**EFFECTIVE DATE: January 1, 2021**

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

**IMPLEMENTATION DATE: July 6, 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	12/190.3.1 - Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits
R	12/190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

**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:**



Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
	services are span-dated on the claim (i.e., the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).										
12068.2	CWF shall display the revised Telehealth frequency limitations data on all CWF provider query screens, including the next eligible date.									X	HETS, NGD
12068.3	Contractors shall be aware of the manual updates in Publication 100-04, Chapter 12, Section 190.3.5, contained in this change request.	X	X								

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
12068.4	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:

### **190.3.1 - Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits**

*(Rev. 10716; Issued: 04-06-21; Effective: 01-01-21; Implementation: 07-06-21)*

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source.

Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient or emergency department consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site.

The use of a telecommunications system may substitute for an in-person encounter for emergency department or initial and follow-up inpatient consultations.

Medicare A/B MACs (B) pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met:

- An inpatient or emergency department consultation service is distinguished from other inpatient or emergency department evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices;
- A request for an inpatient or emergency department telehealth consultation from an appropriate source and the need for an inpatient or emergency department telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- After the inpatient or emergency department telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

Unlike inpatient or emergency department telehealth consultations, the majority of subsequent inpatient hospital, emergency department and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days. *Beginning with dates of service on and after January 1, 2021, the limit for nursing facility care services is one telehealth visit every 14 days.*

### **190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services**

*(Rev. 10716; Issued: 04-06-21; Effective: 01-01-21; Implementation: 07-06-21)*

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. *Beginning with dates of service on and after January 1, 2021, the limit for nursing facility care services is one telehealth visit every 14 days.* Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter.



Displaying title 42, up to date as of 1/20/2022. Title 42 was last amended 1/18/2022.

## Title 42 - Public Health

### Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

#### Subchapter B - Medicare Program

#### Part 424 - Conditions for Medicare Payment

#### Subpart B - Certification and Plan Requirements

#### § 424.20 Requirements for posthospital SNF care.

Medicare Part A pays for posthospital SNF care furnished by an SNF, or a hospital or CAH with a swing-bed approval, only if the certification and recertification for services are consistent with the content of paragraph (a) or (c) of this section, as appropriate.

(a) *Content of certification* -

(1) *General requirements.* Posthospital SNF care is or was required because -

- (i) The individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter, or for a new condition that arose while the individual was receiving care in the SNF or swing-bed hospital for a condition for which he or she received inpatient care in a participating or qualified hospital; or
- (ii) The individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required level of care, as provided in § 409.30 of this chapter.

(2) *Special requirement for certifications performed prior to July 1, 2002: A swing-bed hospital with more than 49 beds (but fewer than 100) that does not transfer a swing-bed patient to a SNF within 5 days of the availability date.* Transfer of the extended care patient to the SNF is not medically appropriate.

(b) *Timing of certification* -

- (1) *General rule.* The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.
- (2) *Special rules for certain swing-bed hospitals.* For swing-bed hospitals with more than 49 beds that are approved after March 31, 1988, the extended care patient's physician has 5 days (excluding weekends and holidays) beginning on the availability date as defined in § 413.114(b), to certify that the transfer of the extended care patient is not medically appropriate.

(c) *Content of recertifications.*

- (1) The reasons for the continued need for posthospital SNF care;
- (2) The estimated time the individual will need to remain in the SNF;
- (3) Plans for home care, if any; and
- (4) If appropriate, the fact that continued services are needed for a condition that arose after admission to the SNF and while the individual was still under treatment for the condition for which he or she had received inpatient hospital services.

(d) *Timing of recertifications.*

- (1) The first recertification is required no later than the 14th day of posthospital SNF care.
- (2) Subsequent recertifications are required at least every 30 days after the first recertification.

(e) *Signature.* Certification and recertification statements may be signed by -

- (1) The physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case; or
- (2) A physician extender (that is, a nurse practitioner, a clinical nurse specialist, or a physician assistant as those terms are defined in section 1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section -

(i) *Collaboration.*

- (A) Collaboration means a process whereby a physician extender works with a doctor of medicine or osteopathy to deliver health care services.
- (B) The services are delivered within the scope of the physician extender's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the physician extender and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) *Types of employment relationships.*

(A) **Direct employment relationship.** A direct employment relationship with the facility is one in which the physician extender meets the common law definition of the facility's "employee," as specified in §§ 404.1005, 404.1007, and 404.1009 of title 20 of the regulations. When a physician extender meets this definition with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(B) **Indirect employment relationship.**

(1) When a physician extender meets the definition of a direct employment relationship in paragraph (e)(2)(ii)(A) of this section with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(2) An indirect employment relationship does not exist if the agreement between the entity and the facility involves only the performance of delegated physician tasks under § 483.30(e) of this chapter.

(f) **Recertification requirement fulfilled by utilization review.** A SNF may substitute utilization review of extended stay cases for the second and subsequent recertifications, if it includes this procedure in its utilization review plan.

(g) **Description of procedures.** The SNF must have available on file a written description that specifies the certification and recertification time schedule and indicates whether utilization review is used as an alternative to the second and subsequent recertifications.

[53 FR 6634, Mar. 2, 1988, as amended at 54 FR 37275, Sept. 7, 1989; 58 FR 30671, May 26, 1993; 60 FR 38272, July 26, 1995; 62 FR 46037, Aug. 29, 1997; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998; 66 FR 39600, July 31, 2001; 70 FR 45055, Aug. 4, 2005; 75 FR 73626, Nov. 29, 2010; 82 FR 36635, Aug. 4, 2017; 83 FR 39290, Aug. 8, 2018]

Version 03/03/2022  
Check for Updates

## 60 - Swing-Bed Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Swing-bed services must be billed separately from inpatient hospital services. Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI. NOTE: The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.):

"U" = short-term/acute care hospital swing-bed;  
"W" = long-term hospital swing-bed;  
"Y" = rehabilitation hospital swing-bed; and  
"Z" = CAH swing-bed.

Note that CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)). Certified registered nurse anesthetist services paid on a pass-through basis are also to be included on the CAH swing-bed bill.

**A. - Inpatient Hospital Services in a Swing-Bed**

The patient status code of 03 is inserted on the claim when the beneficiary swings from acute to SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The A/B MAC (A) indicates in the Statement Covers Through Date the last day of care at the hospital level.

If the beneficiary is discharged from a Medicare swing-bed and remains in the hospital, there is no need for a no-pay bill. However, if a beneficiary continues to receive care after completing their stay in a SNF swing-bed, in a NF swing-bed, the hospital must submit covered claims to Medicare.

**B. - SNF Services in a Swing-Bed**

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;
- State level agreements may call for varying types of bill coding Type of Bill. The CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the A/B MAC (A) accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, i.e., 18X or 21X. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown.

## 10 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

*(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)*

All SNF Part A inpatient services are paid under a prospective payment system (PPS). Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predetermined time period. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care Services Under Hospital Insurance," §20.2, for further information on the 30-day transfer requirement and exception.) To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or for a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

Also under SNF PPS all Medicare covered Part A services that are considered within the scope or capability of SNFs are considered paid in the PPS rate. In some cases this means that the SNF must obtain some services that it does not provide directly. Neither the SNF nor another provider or practitioner may bill the program for the services under Part B, except for services specifically excluded from PPS payment and associated consolidated billing requirements.

Any DME or oxygen furnished to inpatients in a covered Part A stay is included in the SNF PPS rate. The definition of DME in §1861(n) of the Social Security Act (the Act) provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §110.)

*Most prosthetics and all orthotic devices are included in the Part A PPS rate. An exception involves certain designated customized prosthetic devices that are specifically identified as being outside the rate (see the regulations at 42 CFR 411.15(p)(2)(xvi) and Major Category III.D of the SNF consolidated billing editing). Those customized prosthetic devices that are considered outside the PPS rate are billed by the qualified outside entity that furnished the service. That entity bills its normal MAC.*

Services that are not considered to be furnished within SNF PPS are identified in sections §§20.1 - 20.4. These may be billed separately under Part B. Some services must be billed by the SNF. (This is referred to as "consolidated billing.") Some services must be billed by the rendering provider (SNF or otherwise). These are discussed further in §§20.1 - 20.4.

## 10.1 - Consolidated Billing Requirement for SNFs

*(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)*

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing (**CB**) for SNFs. Under the **CB** requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 - 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B (see §20.5). A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit (DPU) of a larger institution. Under the regulations at 42 CFR 411.15(p)(3)(i)-(iv), if such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF "resident" for CB purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when any one of the following events occurs:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary receives services from a Medicare-participating home health agency under a plan of care;
- The beneficiary receives one of the types of outpatient hospital services that CMS has designated as being exceptionally intensive (see §20.1.2); or
- The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before the following midnight. This provision is sometimes referred to as the "midnight rule" (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §20.1, which specifies that an inpatient day ". . . begins at midnight and ends 24 hours later"). A "discharge" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

When a beneficiary is absent from the SNF overnight (i.e., the absence from the SNF spans midnight), the beneficiary's status as a SNF "resident" for CB purposes would end upon the point of departure from the SNF (per the above-described "midnight rule"), and would not resume until the actual point of arrival back at the SNF the next day. Accordingly, that beneficiary would not be considered a SNF "resident" for CB purposes between those two points, so that any offsite services furnished during the interim (such as an overnight sleep study) would not be subject to CB.

It should be noted that the scenarios described in the first three clauses above would become relevant only if a beneficiary leaves the SNF but then arrives back in that or

another SNF before the following midnight. This is because under the “midnight rule” discussed in the fourth clause, whenever a beneficiary leaves the SNF but does not arrive back in that or another SNF later on that same day, the beneficiary’s “resident” status for CB purposes would end immediately upon departure--before any of the other events described in the first three clauses could even occur.

By contrast, when a beneficiary does return to that or another SNF by the end of the same day (a scenario that normally would serve to maintain the beneficiary’s status as a “resident” of the originating SNF throughout the absence), the occurrence of one of the intervening events listed in the first three clauses above would nevertheless serve to end the beneficiary’s “resident” status at that point. For example, when a beneficiary leaves the SNF to receive outpatient emergency services at the hospital, the emergency services would never be subject to CB—even in a situation where the beneficiary returns to the SNF later that same day—because the receipt of the emergency services themselves under the third clause above would have already served to suspend the beneficiary’s SNF “resident” status with respect to those services under the regulations at 42 CFR 411.15(p)(3)(iii).

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the A/B MAC (A) on the ASC X12 837 institutional format or Form CMS-1450. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF’s Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical therapy, occupational therapy, and/or speech-language pathology services provided to a SNF resident under Part B. The **CB** provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to “unbundle” services to an outside supplier that can then submit a separate bill directly to an A/B MAC (B) or DME MAC for residents in a Part A stay, or for SNF residents receiving physical therapy, occupational therapy, and/or speech-language pathology services paid under Part B. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the A/B MAC (A), or (B), or DME MAC or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

**NOTE:** The requirements for participation at 42 CFR 483.15(c)(1)(i)(A)-(F) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care.

However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the **CB** requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the basis of the beneficiary having exhausted his or her benefits, but rather, on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for **CB** purposes.

Enforcement of **CB** is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the **CB** provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to CB. Such transmittals can be found on the CMS Web site at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> or <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>. *Step-by-step instructions for accessing the exclusion list itself appear in the Medicare Benefit Policy Manual, Chapter 8, §10.2.*

The list of HCPCS codes enforcing CB may be updated each quarter. For the notice on CB for the quarter beginning January, separate instructions are published for A/B MACs (A) and A/B MACs (B)/DME MACs. Since this is usually the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. Some non-January quarterly updates may apply to each of A/B MACs (A) and (HHH) and A/B MACs (B)/DME MACs, and the applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **Effective July 1, 1998**, **CB** became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical therapy, occupational therapy, and/or speech-language pathology services in a noncovered stay. SNFs became subject to **CB** once they transitioned to PPS. Due to systems limitations, **CB** was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of **CB** altogether, except for physical therapy, occupational therapy, and/or speech-language pathology services. In addition, for either type of resident, the following requirements were also delayed: (1) that the physicians forward the technical

portions of their services to the SNF; and (2) the requirement that the physician enter the facility provider number of the SNF on the claim.

- **Effective July 1, 1998**, under 42 CFR 411.15(p)(3)(iii) published on May 12, 1998, a number of other services are excluded from **CB**. The hospital outpatient department will bill these services directly to the A/B MAC (A) when furnished on an outpatient basis by a hospital or a critical access hospital (see §20.1.2). Physician's and other practitioner's professional services will be billed directly to the A/B MAC (B) (see §20.1.1). Hospice care (see §20.2.2) and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident (see §20.3), are also excluded from **CB**.
- **Effective April 1, 2000**, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from **CB** that therefore had to be billed directly to the A/B MAC (B) or DME MAC by the provider or supplier for payment (see §20.3). As opposed to whole categories of services being excluded, only certain specific services and drugs (identified by HCPCS code) were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services, and certain customized prosthetic devices.
- **Effective January 1, 2001**, §313 of the BIPA, restricted **CB** to the majority of services provided to beneficiaries in a Medicare Part A covered stay and only to therapy services provided to beneficiaries in a noncovered stay (see §20.5).
  - **Effective for claims with dates of service on or after April 1, 2001**, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, physicians are required to forward the technical portions of any services to the SNF to be billed by the SNF to the A/B MAC (A) for payment (see §20.1.1).

## 10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

*(Rev. 4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)*

Consolidated billing applies to:

- Participating SNFs;
- Short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing-bed hospitals, except *critical access hospitals (CAHs)* certified as swing bed hospitals *(however, while a CAH's SNF-level swing bed services are not subject to consolidated billing, they remain subject to the bundling requirement for hospitals, as specified in the Medicare Claims Processing Manual, Chapter 3, §60). Rural (non-CAH) swing bed hospitals that furnish SNF-level services are*

*subject to **both** the consolidated billing **and** hospital bundling requirements (see §100.1); accordingly, as explained in the FY 2002 SNF PPS final rule (66 FR 39593, July 31, 2001), for the small number of services (such as dialysis) that are excluded from consolidated billing but remain subject to hospital bundling, the billing responsibility would remain with the rural swing bed hospital itself (in accordance with the hospital bundling requirement), but it would use a separate inpatient Part B claim to bill for those services outside of the bundled SNF PPS rate (in recognition of their exclusion from the consolidated billing requirement).*

But *consolidated billing* does not apply to:

- A nursing home that is not Medicare-certified, such as:
  - A nursing home that does not participate at all in either the Medicare or Medicaid programs;
  - A non-certified part of a nursing home that also includes a participating distinct part SNF unit; and
  - A nursing home that exclusively participates in the Medicaid program as an NF.
- CAHs certified as swing-bed hospitals. *However, as noted above*, CAH swing-bed services are subject to the hospital bundling requirement at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m).

codes), and the related rural or urban rate tables. A/B MACs (A) must set the Federal PPS Blend Indicator in the Provider-Specific file to “4.” The CMI ADJ CPD field should be blank.

Unless exceptions are noted, instructions applicable to SNFs are also applicable to swing bed providers e.g., demand bills, spell of illness, covered and noncovered days, nonpayment bills, and adjustment bills.

### **100.1 - Swing Bed Services Not Included in the Part A PPS Rate** *(Rev. 4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)* **PM A-02-016**

*For their SNF-level inpatients, rural (non-CAH) swing bed hospitals must submit all services that are not specifically excluded from consolidated billing on their Part A swing bed bill (TOB 18x). However, they are eligible for additional payment outside the bundled SNF PPS rate for those services that are excluded from the SNF Part A consolidated billing requirements. Further, because the swing bed hospital itself still remains subject to the hospital bundling requirements specified in §1862(a)(14) of the Act and in 42 CFR 411.15(m), it retains the Medicare billing responsibility for any excluded services to which the hospital bundling provision applies. Accordingly, it would use a separate inpatient Part B claim to bill for such services (see §10.2 of this chapter).*

*As noted above, if a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services, which is excluded from the Part A PPS rate, the swing bed hospital may submit a separate bill to the A/B MAC (A) for the SNF PPS-excluded service. This bill must use TOB 13x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information and will be paid as inpatient Part B services under the Outpatient Prospective Payment System (OPPS). (By contrast, those services bundled into the SNF PPS rate may not be billed separately, and must all be included on the Part A swing bed bill (TOB 18x).) A list of services that are excluded from the SNF PPS rate is found in §§20.1 - 20.4 above.*

Likewise, swing bed hospitals may file bills with the A/B MAC (A) for Part B Ancillary services furnished to beneficiaries who are not in a Part A PPS swing bed stay. Such claims are billed as inpatient Part B services, and are paid under the OPPS.

## 100.2 - Payment for CRNA or AA Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

This section discusses reasonable cost-based payment for CRNA services (42 CFR § 412.113(c)). Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Anesthesia services furnished on or after January 1, 1989, and before January 1, 1990, at a rural hospital or CAH by a qualified hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The A/B MAC (A) determines the hospital's qualification using the following criteria:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.
- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- The hospital or CAH must demonstrate that during the 1987 calendar year, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH must agree in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

In addition to the criteria described above, to maintain eligibility for reasonable cost-based payment for services furnished on or after January 1, 1990, a hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 800 procedures.

If a hospital or CAH did not qualify for reasonable cost-based payment for CRNA or AA services in calendar year 1989, it can qualify in subsequent years if it demonstrates to the Medicare Contractor prior to the start of the calendar year that it met these criteria noted below:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.

- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.
- The hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 800 procedures.

Effective for calendar years beginning January 1, 1991, the A/B MAC (A) determines the number of surgical procedures for the immediately preceding year by summing the number of surgical procedures for the 9-month period ending September 30, annualized for a 12-month period.

Effective December 2, 2010, in addition to a hospital or CAH that is located in a rural area (as defined for PPS purposes), a hospital or CAH may be eligible to be paid based on reasonable cost for CRNA or AA services, if the hospital or CAH has reclassified as rural under 42 Code of Federal Regulations 412.103.

To prevent duplicate payments, the A/B MAC (A) informs A/B MACs (B) of the names of CRNAs or AAs, the hospitals and/or CAHs with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished after the hospital's and/or CAH's election of reasonable cost payments, the A/B MAC (B) must recover the overpayment from the CRNA or AA.

Since a swing-bed is a bed that is available for use to provide acute inpatient care or SNF-level care and the CRNA/AA pass-through provision applies to hospital inpatients, CRNA and AA services provided to hospital and CAH swing-bed patients under the pass-through provision must be included on the hospital or CAH swing-bed bill.

### **250.3.3 - Anesthesia and CRNA Services in a Critical Access Hospital (CAH)**

(Rev. 616, Issued: 07-22-05, Effective: 10-01-02, Implementation: 01-03-06)

#### **250.3.3.1 - Payment for CRNA Pass-Through Services**

(Rev.4295, Issued: 05-03-19, Effective: 08-27-19, Implementation: 08-27-19)

CAHs are eligible to receive CRNA pass-through payments (“pass-through exemption”) for both inpatient and outpatient services if they meet criteria discussed at 42 CFR § 412.113(c) of the regulations. CRNA pass-through payments and the Method II election for outpatient CAH services are applied as described below. Note that for CAHs that have a CRNA pass-through exemption, all CRNA services provided to CAH swing-bed patients must be included on the CAH swing-bed bill. (See MCPM, Ch. 3, 60 and 100.2 for more information)

If a CAH meets the criteria for a pass-through exemption and is interested in selecting Method II for its physicians and/or other practitioners, it can choose Method II for all outpatient professionals except the CRNA, and still retain the approved CRNA pass-through exemption for both inpatient and outpatient CRNA professional services.

Alternatively, a CAH, with an approved pass-through exemption, can choose to give up its pass-through exemption for both inpatient and outpatient CRNA professional services in order to include its CRNA outpatient professional services under Method II. By choosing to include the CRNA under Method II for outpatient services, the CAH loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the A/B MAC (B) for the CRNA inpatient professional services. All A/B MAC (A) payments for CRNA services are subject to cost settlement.

#### **Provider Billing Requirements for CRNA Pass-Through**

TOBs = 11X and 18X

Revenue Code 037X for  
 CRNA technical services  
 Revenue Code 0964 for  
 Professional services

### **Reimbursement**

Revenue Code 37X, CRNA technical service = Cost Reimbursement (101 percent of reasonable cost)

Revenue Code 0964, CRNA professional service = Cost Reimbursement (100 percent of reasonable cost) for both inpatient (including swing-bed) and outpatient

Deductible and coinsurance apply.

### **Provider Billing Requirements for CRNA Pass-Through**

TOB = 85X

Revenue Code 037X for  
 CRNA technical services  
 Revenue Code 0964 for  
 Professional services

Anesthesia HCPCS codes and for any HCPCS codes for services the CRNA is legally authorized to perform in the state in which the services are furnished. The appropriate HCPCS should be included when required for the applicable TOB and or revenue code.

### **Reimbursement**

Revenue Code 37X, CRNA technical service = Cost Reimbursement (101 percent of reasonable cost)

Revenue Code 0964, CRNA professional service = Cost Reimbursement (100 percent of reasonable cost) for both inpatient (including swing-bed) and outpatient

Deductible and coinsurance apply.

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Version 03/03/2023  
Check for Updates

**From:** [CMS](#)  
**To:** [Debbie A. Mackaman](#)  
**Subject:** RE: CMS case number 2016-85040  
**Date:** Thursday, June 02, 2016 11:34:07 AM

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Dear Ms. Mackaman:

Thank you for your inquiry regarding Critical Access Hospital (CAH) swing bed policy.

There doesn't seem to be CAH-specific guidance specifically for this issue. However, the CAH should include the related surgery on its swing-bed claim, based this off of Chapter 6 of the Medicare Claims Processing Manual, section 20.1.2.1.

#### 20.1.2.1 Outpatient Surgery and Related Procedures – INCLUSION

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgical procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself. Additionally, this was the approach originally taken in the regulation to present this information.

Medicare contractors are in the best position to be of assistance to people in their area. In addition to processing claims and reimbursing Medicare providers for services rendered to Medicare beneficiaries, it is the responsibility of Medicare contractors to conduct provider education and provide technical assistance.

Therefore, to be as helpful as possible, we suggest that you direct any questions you may have to your local Medicare contractor at their toll-free number which may be found on the Centers for Medicare & Medicaid Services website at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance/interactive/map/index.html>.

For additional information, please visit the Medicare Learning Network website below:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>

I hope this information is helpful.

Please do not reply to this message. Replies to this message are routed to an unmonitored mailbox. If you have questions, please visit <https://questions.cms.gov/login.php> and login to access and respond to past requests.

### Original Request

When a CAH swing bed patient requires a medically necessary outpatient surgery (i.e. toe amputation related to skilled services), should the CAH discharge from the swing bed, perform the surgery as an OP and then readmit to the swing bed if skilled services are still required and the patient is within 30 days of an acute qualifying stay? The Major Categories Excluded list does not apply to a swing bed paid under cost and it is not appropriate to place the patient on an LOA since you can't be an IP and an OP at the same time. Thank you for the clarification.



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## Medicare Part A

### Swing Bed Billing Clarification

 CMS has confirmed that services provided under arrangements to Critical Access Hospital (CAH) swing bed patients are to be bundled to the swing bed claim, rather than billed separately as hospital outpatient services. Accordingly, NAS has removed the system edit that precluded billing MRI services under a 018X type of bill.

 Swing beds affiliated with non-CAH hospitals are subject to SNF Consolidated Billing provisions, and should bill services excluded from SNF Consolidated Billing separately as hospital outpatient services.

Both CAH and non-CAH swing bed providers are reminded that when a patient no longer is eligible for Part A skilled coverage in a swing bed, the patient reverts to being a hospital patient and services should be billed according to the hospital inpatient Part B provisions. A listing of services that can be billed as inpatient Part B services under type of bill 012X can be found in the Internet Only Manual Medicare Benefit Policy Manual, Publication 100-02, Chapter 6, Section 10 at <http://www.cms.gov/manuals/Downloads/bp102c06.pdf> on the CMS website.

Posted: 5/16/2011

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