Medicare
Skilled Nursing Facility Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2362

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

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Not applicable

Section 515.1, Coverage and Patient Classification. This transmittal is a correction to the previously published assessment windows, including grace days. The window for Days 80-94 was incorrectly printed as Days 80-92.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

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

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

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

- o Cardiac catheterization services,
- o Computerized axial tomography (CT scans),
- o Magnetic resonance imaging (MRIs),
- o Radiation therapy,
- o Ambulatory surgery involving the use of a hospital operating room,
- o Emergency services,
- o Angiography services,
- o Lymphatic and venous procedures,
- o Ambulance services that convey a beneficiary to a facility to receive any of the previously mentioned excluded outpatient hospital services,

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

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

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

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

1. Rehabilitation;
2 Extensive care;
3. Special care; or
4. Clinically complex

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

MEDICARE ASSESSMENT SCHEDULE

Medicare MDS Assessment Type	Assessment Window (including authorized grace days)	Maximum Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 day	Days 1 - 8*	14	1 through 14
14 day	Days 11 - 19	16	15 through 30
30 day	Days 21 - 34	30	31 through 60
60 day	Days 50 - 64	30	61 through 90
90 day	Days 80 - 94	10	91 through 100

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

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

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

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