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Special "Skilled Nursing Facility" (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or "Spell of Illness"

Provider Types Affected

Skilled Nursing Facilities (SNFs), Durable Medical Equipment (DME) Suppliers billing Medicare fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), or DME MACs.

What You Need to Know

This article is for informational purposes only and does not represent any change in policy. Instead, it reinforces existing policy by providing legal, regulatory, and Medicare manual references for:

- The definitions of SNFs and NFs;
- The policies applicable to restricting payment for DME coverage in SNFs; and
- The definition of the benefit period and of how one benefit period ends and another begins, especially as it applies to residents of SNFs.

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Skilled Nursing Facility (SNF) Restriction on Coverage of Durable Medical Equipment (DME)

Coverage of a beneficiary's skilled nursing facility (SNF) stay under Part A (the Original Medicare Plan's hospital insurance program) encompasses the overall package of institutional care that the SNF furnishes during the course of the beneficiary's Medicare-covered stay. This comprehensive Part A coverage includes durable medical equipment (DME) under the heading of ". . . drugs, biologicals, supplies, appliances, and equipment . . ." as stated in Section 1861(h)(5) of the Social Security Act (the Act). (The Social Security Act is available at http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm on the Internet.)

When a beneficiary's SNF stay does not qualify for Part A coverage (no qualifying 3-day hospital stay, SNF level of care not met, etc.), Part B (the supplementary medical insurance program) generally can still provide limited coverage for certain individual "medical and other health services" described in Section 1861(s) of the Act. However, as explained below, the scope of coverage under the Part B benefit for DME (Section 1861(s)(6) of the Act) specifically excludes items that are furnished for use in the SNF setting.

Section 1861(n) of the Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. This provision further specifies that any institution meeting the basic definition of a hospital in Section 1861(e)(1) of the Act, or of an SNF in Section 1819(a)(1) of the Act, cannot be considered a patient's "home" for this purpose. Section 1819(a)(1) (formerly Section 1861(j)(1)) of the Act, in turn, defines an "SNF" broadly as any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.

This expansive SNF definition omits the specific, more restrictive elements contained in the remainder of Sections 1819(a)-(d) of the Act, which list the detailed requirements that an institution must meet in order to participate in the Medicare program as a *certified* SNF. Thus, in excluding Part B coverage for DME furnished in "SNFs" as defined broadly in Section 1819(a)(1) of the Act, Congress intended for this exclusion to encompass not only all *Medicare-participating* SNFs, but also any other institutions which, though not participating in Medicare, do provide the type of care described in that section of the law. This policy is also reflected in the regulations in title 42 of the Code of Federal Regulations (42 CFR) at §410.38(b), and in Chapter 15, Section 110.1.D of the *Medicare Benefit Policy Manual*, which is available at <http://www.cms.hhs.gov/manuals/iom/list.asp> on the CMS website.

The blanket prohibition that Congress imposed on any separate Part B payment for DME furnished in this setting (See §144(d) of the Social Security Amendments of 1967, Public Law 90-248) would appear to reflect the view that any institution whose primary function is to provide skilled care to its residents would have an

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inherent responsibility to dispense DME, when needed. This would mean that payment for such items is already an integral part of the skilled facility's basic inpatient rate. Accordingly, any separate, additional DME payment under Part B in this situation would be redundant. Modifying or eliminating the statutory prohibition on Part B payment for DME furnished in this setting would require legislation to amend the law itself.

Additional Considerations for DME Furnished in Medicaid-Only Nursing Facilities (NFs)

Additional considerations apply in determining whether a Medicaid-only nursing facility (NF) would meet the basic SNF definition in this context. Medicaid NFs were created when the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Public Law 100-203) enacted nursing home reform legislation that combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category. Prior to the OBRA 1987 changes, Medicaid SNFs were *always* considered to meet the law's basic definition of an SNF, while pursuant to a U.S. District Court decision in *Kron v. Heckler* (E.D. La., October 17, 1983), those facilities licensed or certified solely as ICFs were *never* considered to meet the basic SNF definition.

The parallel Medicare SNF and Medicaid NF definitions that OBRA 1987 established in Sections 1819(a)(1) and 1919(a)(1) of the Act, respectively, both turn on the type of care that the facility is primarily engaged in furnishing. However, while the NF definition in Section 1919(a)(1) of the Act contains a clause (A) for skilled nursing and a clause (B) for rehabilitation services that are identical to their SNF counterparts in Section 1819(a)(1) of the Act, it also contains an additional clause (C) for health-related institutional care above the level of room and board (comparable to the type of care furnished by ICFs prior to OBRA 1987), which is not found in the SNF definition.

Thus, if a Medicaid NF is primarily engaged in furnishing skilled care under either clauses (A) or (B) of Section 1919(a)(1) of the Act, it would meet the basic SNF definition and cannot be considered a "home" for purposes of DME coverage under Part B. Alternatively, if the NF is primarily engaged in furnishing essentially ICF-level care under clause (C) of this provision, it *would not* meet the basic SNF definition and *can* be considered a home for DME coverage purposes. Thus, because some NFs meet the basic SNF definition while others do not, NFs cannot as a class *automatically* be regarded as either qualifying or not qualifying as a "home" for DME coverage purposes and, therefore, must be evaluated individually under the administrative criteria discussed below.

Administrative Criteria

Administrative criteria to identify those institutions that meet the basic SNF definition are used by each of the State agencies that survey the individual

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institutions within their jurisdictions, and appear in Chapter 2, Section 2166 of the *State Operations Manual*. This manual is also available at <http://www.cms.hhs.gov/manuals/iom/list.asp> on the CMS website. These criteria also were published in the *Federal Register* as HCFA Rulings 83-2 (47 FR 54551, December 3, 1982) and 83-3 (49 FR 10710, March 22, 1984). Historically, it has been the State survey agency's responsibility to evaluate an institution in terms of these criteria. This evaluation reflects the type of care that the institution provides to its residents *generally* (rather than the type of care that an individual resident may be receiving at a given point in time), because the requirements of the law relate to the type of care that an institution is *primarily engaged* in providing to its overall resident population.

Further, as indicated in Chapter 2, Section 2164 of the *State Operations Manual*, States can choose to incorporate the requirements of Section 1819(a)(1) of the Act directly into their own facility licensure standards. In a State that elects to adopt this approach, simply ascertaining that a particular nursing home is licensed under the applicable facility category of State law can also serve to confirm that the facility meets the basic SNF definition in Section 1819(a)(1) of the Act.

Applying the Criteria in Institutions That Contain a Participating "Distinct Part"

Generally, the determination of whether an institution meets the basic SNF definition is made by evaluating it *as a single unit* rather than by separately evaluating and classifying individual areas within the institution. In order to categorize a particular portion of an institution separately from the remainder of that institution, it is necessary for that portion to constitute a "distinct part," i.e., a separate, physically identifiable unit consisting of all the beds in a particular building, floor, wing, or ward (see the regulations at 42 CFR 483.5(b)).

In this situation, if the participating distinct part of an institution meets the basic SNF definition and the remainder of the institution does not, DME payment would be available under Part B only in the portion of the institution that qualifies as a "home" for DME coverage purposes by virtue of *not meeting* the basic SNF definition. Part B payment would not be available for DME furnished in any part of the institution that is identified as meeting the basic SNF definition, regardless of the type of care that a particular resident may be receiving there.

A more detailed discussion of situations in which part of an institution meets the basic SNF definition and part of it does not appears in Chapter 5, Section 1 of the *Medicare Program Integrity Manual*, also available at <http://www.cms.hhs.gov/manuals/iom/list.asp> on the CMS website. This is the same material that originally appeared in Section 4105.1 of the Medicare Carriers Manual, Part 3 (CMS Publication 14-3).

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The Basic SNF Definition and the Medicare Policy on Ending a Benefit Period, or “Spell of Illness”

The special, broad definition of an SNF discussed above in connection with the DME coverage exclusion also figures in another aspect of Medicare policy, regarding the ending of a benefit period in an SNF. The law (at Section 1812(a)(2)(A) of the Act) provides for a maximum of 100 days of SNF benefits in a benefit period, or “spell of illness” (see Section 1861(a) of the Act). Medicare uses the benefit period concept to keep track of how many of these 100 days of SNF coverage a beneficiary has used, and how many are still available. A benefit period starts on the day that a beneficiary begins receiving Part A hospital or SNF benefits. Once the 100 days of SNF benefits available in the benefit period have been exhausted, they cannot be renewed until the current benefit period ends. Under Section 1861(a)(2) of the Act, this occurs when a period of 60 consecutive days has elapsed throughout which the beneficiary has not been an inpatient of a hospital or an SNF.

There is no limit to the number of benefit periods that a beneficiary can have. However, after a given benefit period ends, the beneficiary must once again meet all of the requirements for SNF coverage (3-day qualifying hospital stay, timely transfer to a Medicare-participating SNF, etc.) in order to begin utilizing the 100 days of renewed SNF benefits. The law’s reference to a benefit period as a “spell of illness” sometimes leads to the mistaken belief that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and unrelated condition could serve to end the benefit period. In fact, however, this does not end the benefit period, which can occur in an SNF only under the circumstances described below.

As noted previously, Section 1861(a)(2) of the Act provides, in part, that a benefit period ends after a beneficiary has not been an inpatient of an SNF for 60 consecutive days. In defining an “SNF” for this purpose, this provision uses the same broad SNF definition described in the preceding discussion on the DME coverage exclusion. This is reflected in the benefit period regulations at 42 CFR 409.60(b)(1)(iii), and in Chapter 3, Section 10.4.3.2 of the *Medicare General Information, Eligibility and Entitlement Manual*. This manual is available at <http://www.cms.hhs.gov/manuals/iom/list.asp> on the CMS website.

Special “Inpatient” Definition for Ending a Benefit Period in an SNF

However, unlike in the DME context, the benefit period policy additionally uses a special definition of the term “inpatient” as well. The instructions in Chapter 3, Section 10.4.4 of the *Medicare General Information, Eligibility and Entitlement Manual* indicate that a beneficiary in an institution that meets the basic SNF definition would be considered an “inpatient,” for benefit period purposes, only while actually receiving a skilled level of care there. These instructions also

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contain a set of administrative presumptions that simplify the process for determining whether the beneficiary is, in fact, receiving this level of care. This means that a beneficiary who remains in an SNF can nonetheless end a benefit period, after 60 consecutive days elapse during which the beneficiary does not receive a skilled level of care there (and, thus, is not considered an "inpatient" of the SNF for benefit period purposes).

This special "inpatient" definition, which reflects regulations at 42 CFR 409.60(b)(2), (c), and (d), and the Federal circuit court decision in *Mayburg v. Heckler* (740 F.2d 100 (1st Cir. 1984)), is intended to address situations in which a beneficiary essentially uses the SNF as a place of residence rather than as a provider of ongoing medical care. It is important to note as well that, under this policy, a beneficiary would still be considered an SNF "inpatient" (and his or her current benefit period would continue) for as long as the beneficiary keeps receiving a skilled level of care in the SNF--even if Medicare has stopped paying for the SNF stay due to the beneficiary's exhaustion of Part A benefits.

Thus, if a particular nursing home does not meet the basic SNF definition, a beneficiary's stay in that nursing home would not serve to prolong the current benefit period, regardless of the type of care being received there. Further, even when a beneficiary is in a nursing home that *does* meet the basic SNF definition, the beneficiary can nonetheless end a benefit period there after 60 consecutive days elapse during which he or she is not an "inpatient" of the SNF for benefit period purposes (that is, does not receive a skilled level of care). Accordingly, a nursing home stay would serve to prolong a benefit period *only* if *both* of the following two conditions are met:

- The nursing home meets the basic SNF definition; *and*
- The beneficiary remains an "inpatient," for benefit period purposes, by continuing to receive a skilled level of care there.

Additional Information

If you have any questions regarding this issue, contact your Medicare FI, A/B MAC, or DME MAC at their toll free number, which is available at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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