

(c) The services are of a kind ordinarily furnished to inpatients either by the hospital or CAH or under arrangements made by the hospital or CAH.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993]

§ 409.17 Physical therapy, occupational therapy, and speech-language pathology services.

(a) *General rules.* (1) Except as specified in this section, physical therapy, occupational therapy, or speech-language pathology services must be furnished by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists who meet the requirements specified in part 484 of this chapter.

(2) Physical therapy, occupational therapy or speech-language pathology services must be furnished under a plan that meets the requirements of paragraphs (b) through (d) of this section, or plan requirements specific to the payment policy under which the services are rendered, if applicable.

(b) *Establishment of the plan.* The plan must be established before treatment begins by one of the following:

(1) A physician.

(2) A nurse practitioner, a clinical nurse specialist or a physician assistant.

(3) The physical therapist furnishing the physical therapy services.

(4) A speech-language pathologist furnishing the speech-language pathology services.

(5) An occupational therapist furnishing the occupational therapy services.

(c) *Content of the plan.* The plan:

(1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and

(2) Indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan are implemented in accordance with the provider's policies and procedures.

[72 FR 66397, Nov. 27, 2007, as amended at 73 FR 69932, Nov. 19, 2008; 75 FR 73613, Nov. 29, 2010]

§ 409.18 Services related to kidney transplantations.

(a) *Kidney transplants.* Medicare pays for kidney transplantation surgery only if performed in a renal transplantation center approved under subpart U of part 405 of this chapter.

(b) *Services in connection with kidney donations.* Medicare pays for services related to the evaluation or preparation of a potential or actual donor, to the donation of the kidney, or to post-operative recovery services directly related to the kidney donation—

(1) If the kidney is intended for an individual who has ESRD and is entitled to Medicare benefits or can be expected to become so entitled within a reasonable time; and

(2) Regardless of whether the donor is entitled to Medicare.

Subpart C—Posthospital SNF Care

§ 409.20 Coverage of services.

(a) *Included services.* Subject to the conditions and limitations set forth in this subpart and subpart D of this part, “posthospital SNF care” means the following services furnished to an inpatient of a participating SNF, or of a participating hospital or critical access hospital (CAH) that has a swing-bed approval:

(1) Nursing care provided by or under the supervision of a registered professional nurse.

(2) Bed and board in connection with the furnishing of that nursing care.

(3) Physical therapy, occupational therapy, and speech-language pathology services.

(4) Medical social services.

(5) Drugs, biologicals, supplies, appliances, and equipment.

(6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under § 483.70(j) of this chapter.

(7) Other services that are generally provided by (or under arrangements made by) SNFs.

(b) *Excluded services.*—(1) *Services that are not considered inpatient hospital services.* No service is included as posthospital SNF care if it would not be included as an inpatient hospital service under §§ 409.11 through 409.18.

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(2) *Services not generally provided by (or under arrangements made by) SNFs.* Except as specifically listed in §§ 409.21 through 409.27, only those services generally provided by (or under arrangements made by) SNFs are considered as posthospital SNF care. For example, a type of medical or surgical procedure that is ordinarily performed only on an inpatient basis in a hospital is not included as “posthospital SNF care,” because such procedures are not generally provided by (or under arrangements made by) SNFs.

(c) *Terminology.* In § 409.21 through § 409.36—

(1) The terms *SNF* and *swing-bed hospital* are used when the context applies to the particular facility.

(2) The term *facility* is used to mean both SNFs and swing-bed hospitals.

(3) The term *swing-bed hospital* includes a CAH with swing-bed approval under subpart F of part 485 of this chapter.

(4) The term *post-hospital SNF care* includes SNF care that does not follow a hospital stay when the beneficiary is enrolled in a plan, as defined in § 422.4 of this chapter, offered by a Medicare + Choice (M + C) organization, that includes the benefits described in § 422.101(c) of this chapter.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 58 FR 30667, May 26, 1993; 63 FR 26306, May 12, 1998; 64 FR 3648, Jan. 25, 1999; 64 FR 41681, July 30, 1999; 68 FR 46070, Aug. 4, 2003; 68 FR 50854, Aug. 22, 2003; 69 FR 35529, June 25, 2004; 75 FR 73613, Nov. 29, 2010; 82 FR 32258, July 13, 2017]

§ 409.21 Nursing care.

(a) *Basic rule.* Medicare pays for nursing care as posthospital SNF care when provided by or under the supervision of a registered professional nurse.

(b) *Exception.* Medicare does not pay for the services of a private duty nurse or attendant. An individual is not considered to be a private duty nurse or attendant if he or she is an SNF employee at the time the services are furnished.

[63 FR 26306, May 12, 1998]

§ 409.22 Bed and board.

(a) *Semiprivate and ward accommodations.* Except for applicable deductible and coinsurance amounts Medicare

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Part A pays in full for semiprivate (2 to 4 beds), or ward (5 or more beds) accommodations.

(b) *Private accommodations—*(1) *Conditions for payment in full.* Except for applicable coinsurance amounts, Medicare pays in full for a private room if—

(i) The patient's condition requires him to be isolated;

(ii) The SNF has no semiprivate or ward accommodations; or

(iii) The SNF semiprivate and ward accommodations are fully occupied by other patients, were so occupied at the time the patient was admitted to the SNF for treatment of a condition that required immediate inpatient SNF care, and have been so occupied during the interval.

(2) *Period of payment.* In the situations specified in paragraph (b)(1) (i) and (iii) of this section, Medicare pays for a private room until the patient's condition no longer requires isolation or until semiprivate or ward accommodations are available.

(3) *Conditions for patient's liability.* The facility may charge the patient the difference between its customary charge for the private room furnished and its most prevalent charge for a semiprivate room if:

(i) None of the conditions of paragraph (b)(1) of this section is met, and

(ii) The private room was requested by the patient or a member of the family who, at the time of request was informed what the charge would be.

§ 409.23 Physical therapy, occupational therapy, and speech-language pathology services.

Medicare pays for physical therapy, occupational therapy, or speech-language pathology services as posthospital SNF care if they are furnished—

(a) By (or under arrangements made by) the facility and billed by (or through) the facility;

(b) By qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists as defined in part 484 of this chapter; and

(c) In accordance with a plan that meets the requirements of § 409.17(b) through (d) of this part.

[75 FR 73613, Nov. 29, 2010]

§ 409.24 Medical social services.

Medicare pays for medical social services as posthospital SNF care, including—

(a) Assessment of the social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care in the facility;

(b) Case work services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and

(c) Assessment of the relationship of the beneficiary's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

[63 FR 26306, May 12, 1998]

§ 409.25 Drugs, biologicals, supplies, appliances, and equipment.

(a) *Drugs and biologicals.* Except as specified in paragraph (b) of this section, Medicare pays for drugs and biologicals as posthospital SNF care only if—

(1) They represent a cost to the facility;

(2) They are ordinarily furnished by the facility for the care and treatment of inpatients; and

(3) They are furnished to an inpatient for use in the facility.

(b) *Exception.* Medicare pays for a limited supply of drugs for use outside the facility if it is medically necessary to facilitate the beneficiary's departure from the facility and required until he or she can obtain a continuing supply.

(c) *Supplies, appliances, and equipment.* Except as specified in paragraph (d) of this section, Medicare pays for supplies, appliances, and equipment as posthospital SNF care only if they are—

(1) Ordinarily furnished by the facility to inpatients; and

(2) Furnished to inpatients for use in the facility.

(d) *Exception.* Medicare pays for items to be used after the individual leaves the facility if—

(1) The item is one that the beneficiary must continue to use after leaving, such as a leg brace; or

(2) The item is necessary to permit or facilitate the beneficiary's departure from the facility and is required until he or she can obtain a continuing supply, for example, sterile dressings.

[63 FR 26307, May 12, 1998]

§ 409.26 Transfer agreement hospital services.

(a) *Services furnished by an intern or a resident-in-training.* Medicare pays for medical services that are furnished by an intern or a resident-in-training (under a hospital teaching program approved in accordance with the provisions of § 409.15) as posthospital SNF care, if the intern or resident is in—

(1) A participating hospital with which the SNF has in effect an agreement under § 483.70(j) of this chapter for the transfer of patients and exchange of medical records; or

(2) A hospital that has a swing-bed approval, and is furnishing services to an SNF-level inpatient of that hospital.

(b) *Other diagnostic or therapeutic services.* Medicare pays for other diagnostic or therapeutic services as posthospital SNF care if they are provided—

(1) By a participating hospital with which the SNF has in effect a transfer agreement as described in paragraph (a)(1) of this section; or

(2) By a hospital or a CAH that has a swing-bed approval, to its own SNF-level inpatient.

[63 FR 26307, May 12, 1998; 82 FR 32258, July 13, 2017]

§ 409.27 Other services generally provided by (or under arrangements made by) SNFs.

In addition to those services specified in §§ 409.21 through 409.26, Medicare pays as posthospital SNF care for such other diagnostic and therapeutic services as are generally provided by (or under arrangements made by) SNFs, including—

(a) Medical and other health services as described in subpart B of part 410 of this chapter, subject to any applicable

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limitations or exclusions contained in that subpart or in § 409.20(b);

(b) Respiratory therapy services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function; and

(c) Transportation by ambulance that meets the general medical necessity requirements set forth in § 410.40(e)(1) of this chapter.

[63 FR 26307, May 12, 1998, as amended at 64 FR 41681, July 30, 1999; 84 FR 63187, Nov. 15, 2019]

Subpart D—Requirements for Coverage of Posthospital SNF Care

§ 409.30 Basic requirements.

Posthospital SNF care, including SNF-type care furnished in a hospital or CAH that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31. A beneficiary in an SNF is also considered to meet the level of care requirements of § 409.31 up to and including the assessment reference date for the initial Medicare assessment prescribed in § 413.343(b) of this chapter, when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. For the purposes of this section, the assessment reference date is defined in accordance with § 483.315(d) of this chapter, and must be set for no later than the eighth day of posthospital SNF care.

(a) *Pre-admission requirements.* The beneficiary must—

(1) Have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge; and

(2) Have been discharged from the hospital or CAH in or after the month he or she attained age 65, or in a month for which he or she was entitled to hospital insurance benefits on the basis of

disability or end-stage renal disease, in accordance with part 406 of this chapter.

(b) *Date of admission requirements.*¹ (1) Except as specified in paragraph (b)(2) of this section, the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH.

(2) The following exceptions apply—

(i) A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital or CAH, or a beneficiary enrolled in a Medicare + Choice (M + C) plan, may be admitted at the time it would be medically appropriate to begin an active course of treatment.

(ii) If, upon admission to the SNF, the beneficiary was enrolled in an M + C plan, as defined in § 422.4 of this chapter, offering the benefits described in § 422.101(c) of this chapter, the beneficiary will be considered to have met the requirements described in paragraphs (a) and (b) of this section, and also in § 409.31(b)(2), for the duration of the SNF stay.

[48 FR 12541, Mar. 25, 1983, as amended at 51 FR 41338, Nov. 14, 1986; 58 FR 30666, 30667, May 26, 1993; 62 FR 46025, Aug. 29, 1997; 63 FR 26307, May 12, 1998; 64 FR 41681, July 30, 1999; 68 FR 50584, Aug. 22, 2003; 72 FR 43436, Aug. 3, 2007; 82 FR 36633, Aug. 4, 2017; 84 FR 38832, Aug. 7, 2019]

§ 409.31 Level of care requirement.

(a) *Definition.* As used in this section, *skilled nursing and skilled rehabilitation services* means services that:

(1) Are ordered by a physician;

¹Before December 5, 1980, the law required that admission and receipt of care be within 14 days after discharge from the hospital or CAH and permitted admission up to 28 days after discharge if a SNF bed was not available in the geographic area in which the patient lived, or at the time it would be medically appropriate to begin an active course of treatment, if SNF care would not be medically appropriate within 14 days after discharge.