

§ 409.30

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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.

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) *Specific conditions for meeting level of care requirements.* (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition—

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or

(iii) For which, for an M + C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993; 68 FR 50854, Aug. 22, 2003; 70 FR 45055, Aug. 4, 2005]

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition

or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

[48 FR 12541, Mar. 25, 1983, as amended at 59 FR 65493, Dec. 20, 1994]

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) *Services that could qualify as either skilled nursing or skilled rehabilitation services—*(1) *Overall management and evaluation of care plan.* (i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) *Example.* An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any