

§ 409.27

42 CFR Ch. IV (10–1–07 Edition)

(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]

§ 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 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(d)(1) of this chapter.

[63 FR 26307, May 12, 1998, as amended at 64 FR 41681, July 30, 1999]

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 5-day assessment prescribed in § 413.343(b) of this chapter, when assigned to one of the Resource Utilization Groups that is designated (in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter) 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 occur 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

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.