CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1311	Date: November 6, 2013
	Change Request 8408

SUBJECT: Informational Unsolicited Response (IUR) or Reject for Ambulance SNF to SNF Transfer

**I. SUMMARY OF CHANGES:** The contractor claim data identified suppliers that were billing ambulance claims for SNF to SNF transfer separately under Part B resulting in overpayments. As a result of overpayment for a transport between two SNFs when a beneficiary is in a Part A covered SNF stay, CMS will implement an Informational Unsolicited Response (IUR) and Reject for an ambulance claim when suppliers are billing ambulance claims for SNF to SNF transfer separately under Part B.

**EFFECTIVE DATE: April 1, 2014** 

**IMPLEMENTATION DATE: April 7, 2014** 

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated) R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE	
N/A	N/A	

#### III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers: No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

### For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

#### IV. ATTACHMENTS:

### **One Time Notification**

<sup>\*</sup>Unless otherwise specified, the effective date is the date of service.

# **Attachment - One-Time Notification**

Pub. 100-20 Transmittal: 1311 Date: November 6, 2013 Change Request: 8408

SUBJECT: Informational Unsolicited Response (IUR) or Reject for Ambulance SNF to SNF Transfer

**EFFECTIVE DATE: April 1, 2014** 

**IMPLEMENTATION DATE: April 7, 2014** 

#### I. GENERAL INFORMATION

- A. Background: The CMS Recovery Audit Contractor (RAC) program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service payment process. The contractor claim data identified suppliers that were billing ambulance claims for SNF to SNF transfer separately under Part B resulting in overpayments. The Centers for Medicare & Medicaid Services (CMS) policy indicates: "ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may not be billed as Part B services by the supplier." The SNF discharging the beneficiary to another SNF is financially responsible for the transportation fees and the ambulance providers should seek payment from the transferring SNF. This Change Request will prompt the Medicare contractors to generate an IUR or Reject for an ambulance claims when suppliers are billing ambulance claims for SNF to SNF transfer separately under Part B.
- **B.** Policy: According to Pub 100-04, Medicare Claims Processing Manual Ch. 15, SNF Billing, Section 30.2.2, Ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may not be billed as Part B services by the supplier. Therefore, a transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport.

### II. BUSINESS REQUIREMENTS TABLE

Ambulance claim;

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
			A/B		D	D F		R		Sha	red-		Other
		1	MAC		M	Ι	AH		H System				
					Е		R	Н	M	aint	aine	ers	
		A	В	Н			R	I	F	M	V	C	
				Н	M		I		I	C	M	W	
				Н	A		Е		S	S	S	F	
					C		R		S				
8408.1	The CWF shall create a utility to prepare an IUR for a <b>paid Ambulance</b> claim with a detail line item for a HCPCS service code from Attachment A, and the rendering provider 's specialty code = 59, when the following conditions are met:  1. The Ambulance claim has a final action status, that the claim has not been adjusted, cancelled, or denied;											X	
	2. AND There is a <b>Paid SNF</b> claim, TOB = 21X, for the same HICN as on the												

Number	Requirement Responsibility												
			A/B MA(	3	D M E	F I	C A R	R H H		Sys	red- tem		Other
		A	В	H H H	M A C		R I E R	Ι	F I S S	M C S	V M S	C W F	
	<ol> <li>AND the Discharge Status for the SNF claim equals "03";</li> <li>AND the DOS for the HCPCS Service code from Attachment A, on the Ambulance claim, equals the discharge date of the SNF claim;</li> <li>AND the select claim's date of service for the Attachment A HCPCS is on or after the first day of the month not greater than three (3) years prior to the date of review;</li> <li>AND Exclude any claims that will have an</li> </ol>												
	6. AND Exclude any claims that will have an overpayment adjustment of less than \$10.00												
8408.1.1	The contractor shall issue the adjustment for the Medicare Claim.		X							X			
8408.2	The CWF shall reject a line item for a <b>current</b> Ambulance claim with a detail line item for a HCPCS service code from Attachment A, and the rendering provider 's specialty code = 59, when the following conditions are met:  1. AND There is a paid SNF claim, TOB = 21X, for the same HICN as on the Ambulance claim;  2. AND the Discharge Status for the SNF claim equals "03";  3. AND the DOS for the HCPCS Service code from Attachment A, on the Ambulance claim, equals the discharge date of the SNF claim.											X	
8408.2.1	The contractor shall issue the denial for the Medicare Claim.		X							X			
8408.3	The CWF shall prepare an IUR for a paid Ambulance claim with a detail line item for a HCPCS service code from Attachment A, and the rendering provider 's specialty code = 59, when the following conditions are met:											X	

Number	Requirement	R	ene	onsi	hilif	• • • • • • • • • • • • • • • • • • • •							
Nullibel	Requirement		A/E		1	F	С	R		Sha	red-		Other
		MAC					A	Н			tem		Other
			E		<del>  </del>     _		R	Н	M	aint	aine	ers	
		A	В	Н			R	I	F	M			
				H	M		I E		I	C	M		
				Н	A C		R		S S	S	S	F	
	<ol> <li>AND There is a current SNF claim, TOB = 21X, for the same HICN as on the Ambulance claim;</li> <li>AND the Discharge Status for the SNF claim equals "03";</li> <li>AND the DOS for the HCPCS Service</li> </ol>												
	code from Attachment A, on the Ambulance claim, equals the discharge date of the SNF claim;  4. AND Exclude any claims that will have an overpayment adjustment of less than \$10.00.												
8408.3.1	The contractor shall issue the adjustment for the Medicare Claim.		X							X			
8408.4	The contractors shall have override capability for a claim upon first appeal when it is determined that the claim should have been paid.		X									X	
8408.5	The Medicare claims processing contractors shall use the following group code, MSN message, RARC, and CARC codes when creating an adjustment and a reject for the claim:  1. Group Code - CO;  2. MSN message16.32- Medicare does not pay separately for this service;  3. RARC N390 - This service/report cannot		X										
	<ol> <li>CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</li> </ol>												

Number	Requirement	Responsibility							
			A/B MA(		D M E	F I	C A R	R H H	Other
		A	В	H H H	M A C		R I E R	Ι	
8408.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X						

#### IV. SUPPORTING INFORMATION

## Section A: Recommendations and supporting information associated with listed requirements:

<sup>&</sup>quot;Should" denotes a recommendation.

X-Ref	Recommendations or other supporting information:
Requirement	
Number	
Attachment A	Ambulance Specified HCPCS Codes List

# Section B: All other recommendations and supporting information: N/A

## V. CONTACTS

 $\label{eq:contact} \textbf{Pre-Implementation Contact(s):} \ Megan \ Hayden, 410-786-1970 \ or \ megan.hayden@cms.hhs.gov \ , Carla \ David, 410-786-4799 \ or \ carla.david@cms.hhs.gov \ .$ 

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

#### VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

## **Section B: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.