



Related MLN Matters Article #: SE0433 **Revised**

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Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services

Note: Special Edition (SE) article SE0433 was revised to add language that discusses Medicare's non-coverage of transportation by any means other than ambulance (page 4 below) and to add the note regarding transportation between a skilled nursing facility (SNF) and a physician's office (page 3 below).

Key Words

SE0433, Skilled, Nursing, Facilities, SNF, Consolidated Billing, CB, Ambulance, Radiation, Angiography, Lymphatic, Venous, Procedures

Provider Types Affected

SNFs, physicians, ambulance suppliers, and providers

Key Points

- SE0433 describes SNF as it applies to ambulance services for SNF residents.
- SE0433 was revised on February 18, 2005, to include the following clarifying language:
 - The SNF Consolidated Billing (CB) requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare covered stay, except for a small number of services that are specifically excluded from this provision.
 - These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources.
 - These sources can include other providers of service (such as hospitals), who would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier.
 - Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Medicare Administrative Contractor.
 - Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations (i.e., based on the reason the ambulance service is needed).

- The initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, since the beneficiary has not yet been admitted to the SNF as a resident.
- An ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the following events:
 - A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH);
 - A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care;
 - A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day; or
 - A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).

Ambulance Trips to Receive Excluded Outpatient Hospital Services

- The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes.
- Such outpatient hospital services are excluded from the CB requirement on the basis that they are well beyond the typical scope of the SNF care plan are as follows:
 - Cardiac catheterization;
 - Computerized Axial Tomography Imaging (CT) scans;
 - Magnetic Resonance Imaging (MRI) services;
 - Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
 - Emergency room services;
 - Radiation therapy;
 - Angiography; and
 - Lymphatic and venous procedures.
- Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well.
- Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier.
- Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

- By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF.
- Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is (itself) categorically excluded from the CB requirement.
- However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport a SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

- A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 Code of Federal regulations (CFR) 411.15(p)(3)(iv)).
- Therefore, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies.
- Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.
- However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

- If a SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the Prospective Payment System (PPS) rate.
- The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Note: Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate (by reference *only*) the Part B ambulance benefit's *general medical necessity* requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and *not* any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). **Therefore, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.**

Non-coverage of Transportation by Any Means Other than Ambulance

- In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A *or* Part B for any *non-ambulance* forms of transportation, such as ambulette, wheelchair van, or litter van.
- Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be *medically necessary*-that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.
- This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance (for example, via wheelchair van), the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance also would not be covered (because the use of an ambulance in such a situation would not be medically necessary).
- As with any non-covered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to ". . . *inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.*"

Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf>

MLN Matters article SE0431 provides a detailed overview of SNF CB, including a section on services excluded from SNF CB. It can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS website.

The MLN Consolidated Billing website is at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS website.

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing website can be found at

http://www.cms.hhs.gov/SNFPSPS/05_ConsolidatedBilling.asp on the CMS website.

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).