



Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility (SNF) Stays – JA6700

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Key Words MM6700, CR6700, R595OTN, Ambulance, Services

Contractors Affected

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers
- Fiscal Intermediaries (FIs)

Provider Types Affected SNFs and ambulance suppliers submitting claims to Medicare Carriers, FIs, and/or A/B MACs for ambulance services provided to Medicare beneficiaries



Change Request (CR) 6700 implements additional Medicare system checks to ensure that ambulance services that are subject to SNF consolidated billing (CB) rules (but that are billed separately as a Part B service) are denied when the date of service on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB.

Provider Needs to Know...

- There are exceptions to the general rule that ambulance services furnished to a beneficiary in a SNF Part A stay are subject to SNF CB rules.
- In accordance with the *Medicare Claims Processing Manual*, Chapter 15, Section 30.2.2, ambulance payments associated with the following outpatient hospital service exclusions are paid under the ambulance fee schedule:
 - Cardiac catheterization;
 - Computerized axial tomography scans;

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- Magnetic resonance imaging;
 - Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy tube in the hospital's gastrointestinal or endoscopy suite;
 - Emergency services;
 - Angiography;
 - Lymphatic and Venous Procedures; and
 - Radiation therapy.
- The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF prospective payment system (PPS) rate and **may not be billed as Part B services by the supplier**.
 - A beneficiary's transfer from one SNF to another before midnight of the same day, for which the first SNF is responsible for billing the services to the Part A MAC; and
 - Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility.
 - In these scenarios, the services provided are subject to SNF CB.

CR6700 Additional Medicare System Checks

- The Medicare claims processing system will enforce SNF CB rules by subjecting claims for ambulance services to the following **if-then** logic:
 - **If** a claim for a hospital outpatient service is rejected because it should have been billed and paid for according to SNF CB rules, **then**

Medicare contractors will deny any ambulance service associated with the denied hospital outpatient service as the ambulance transportation is also subject to SNF CB rules, and conversely;
 - **If** payment for a hospital outpatient service is not bundled into the SNF CB rate **and** is separately payable under Part B, **then**

The ambulance service associated with that service is also separately payable under Part B.
 - Where claims are denied as a result of enforcing the SNF CB rules, Medicare will use the following codes:
 - Remittance advice reason code 190 ("Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay."),
 - Remark code N106 ("Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service."), and
 - Group code CO (Contractual Obligation).
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- The Social Security Act (Section 1888(e), http://www.ssa.gov/OP_Home/ssact/title18/1888.htm) established a Medicare PPS for SNFs.
 - Under the SNF PPS, most of the services that outside suppliers provide to SNF residents are included in the SNF's Medicare Part A payments.
 - Most ambulance services furnished to a beneficiary in a SNF Part A stay are subject to this rule as well (exceptions are discussed above).
 - Accordingly, pursuant to the Social Security Act's CB requirements, SNFs are responsible for billing Medicare Part A for these services.
- Background**
- The outside suppliers may not separately bill Medicare but must obtain payment from the SNFs.
 - A Department of Health and Human Services' Inspector General Report A-01-08-00505 dated August 25, 2009, found that on occasion, ambulance services that were subject to the SNF CB rule were improperly billed separately by the supplier.
 - The report may be found at <http://oig.hhs.gov/oas/reports/region1/10800505.asp> on the Internet.
 - The related Code of Federal Regulations may be found at <http://www.gpoaccess.gov/CFR/retrieve.html> on the Internet.
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**Operational
Impact**

If Medicare processes an ambulance claim first and later discovers that the ambulance service was provided during a SNF stay, and the ambulance service should have been bundled under the SNF stay payment, Medicare will consider the separate ambulance claim payment as an overpayment and will initiate overpayment recovery procedures.

**Reference
Materials**

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6700.pdf> on the CMS website.

The official instruction (CR6700) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R595OTN.pdf> on the CMS website.
