



MLN Matters®



Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3933

MLN Matters Number: MM3933

Related CR Release Date: September 2, 2005

Related CR Transmittal #: 668

Effective Date: Ambulance claims received on or after January 3, 2006, and four years after initial determination for adjustments

Implementation Date: January 3, 2006

Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims During an Inpatient Stay

Note: This article was updated on February 12, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Independent ambulance services suppliers billing Medicare carriers

Provider Action Needed



STOP – Impact to You

Independent ambulance services suppliers cannot bill Medicare carriers for ambulance services that they provide to an inpatient of an acute care hospital, LTCH, IRF, or IPF (on or after 12/31/04) unless the services are provided either:

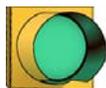
- On the dates of hospital admission and/or discharge; or
- Within an occurrence span code 74 from and through dates plus one day.

If services other than these two scenarios are billed separately as Part B, the bills will be rejected.



CAUTION – What You Need to Know

If an ambulance supplier bills Medicare and is paid prior to Medicare's receipt of the hospital inpatient claim, Medicare will recover the improper payment from the ambulance supplier.



GO – What You Need to Do

Make sure that your billing staffs are aware of these ambulance service billing requirements.

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Background

The Centers for Medicare & Medicaid Services (CMS) is strengthening its claims processing edits to detect incorrect payments and to prevent (or correct) improper payments to ambulance suppliers for transporting hospital inpatients. In CR3933 (on which this article is based), CMS explains the rules that govern payment for the ambulance services that such suppliers provide to hospital inpatients.

Sections 1882(a)(14), 1886(d) and (g) of the Social Security Act, and Code of Federal Regulations (CFR) 411.15(m) disallow payment for ambulance services furnished to hospital inpatients by independent ambulance services suppliers on dates that fall between the patients' admission and discharge dates.

As a result, the independent supplier of ambulance services must look to the hospital for payment for these services, rather than to the Medicare beneficiary or carrier. More specifically, with the exception of services on the admission and discharge dates or ambulance services that fall within the occurrence span code 74 from and through dates plus one day, all ambulance transportation provided to hospital inpatients must be bundled into the hospital bill.

Medicare carriers will reject any bill for ambulance services that are provided to a hospital inpatient on a date that falls between their admission and discharge dates unless they are within occurrence span code 74 from and through dates plus one day.

How the Process Works

In summary, here is how this process works:

- Effective for dates of service on or after December 31, 2004, Medicare's systems search the claim histories and compare the line item service dates (line items with specialty codes of "59") on the ambulance claims to the admission and discharge dates on hospital inpatient stays.
- Medicare then rejects the line items when an ambulance line item service date falls between the admission and discharge dates on a hospital inpatient bill or outside the occurrence span code 74 from and through dates.
- And, if Medicare receives the ambulance claim prior to receiving the hospital inpatient bill, it performs the same search, and if the ambulance claim falls within the admission and discharge dates or outside the occurrence span code 74 from and through dates plus one day, the ambulance claim is adjusted and the incorrect payment for the ambulance service will be recovered from the ambulance supplier.
- Finally, when Medicare rejects/adjusts an ambulance claim, the carrier will indicate, by using Remittance Advice Remark Code M2, "Not paid separately when the patient is an inpatient," that:
 - The ambulance transportation occurred during a hospital inpatient stay (on a date that falls within the admission and discharge dates of a covered hospital inpatient stay), and is not separately payable; or
 - The service date falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an acute care hospital, LTCH, IPF or IRF, and is not separately payable.

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In addition, the carrier will also indicate the adjustment using Remittance Advice (RA) Adjustment Reason Code 97, "Payment is included in the allowance for another service/procedure."

Additional Information

You can find more information about the payment of ambulance claims during an inpatient stay by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R668CP.pdf> on the CMS website.

You might also want to look at the Medicare Claims Processing Manual, Chapter 3 (Inpatient Part A Hospital) Section 10.5 (Hospital Inpatient Bundling). You can find this manual chapter as an attachment to CR3933.

Finally, if you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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