



**News Flash** – The revised publication titled ICD-10-CM/PCS: An Introduction Fact Sheet (August 2009), which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://go.cms.gov/MLNProducts> scroll down to “Related Links” and select “MLN Product Ordering Page.” If you are unable to access the hyperlink in this message, please copy and paste the url into your Internet browser. For more educational resources regarding the ICD-10-CM/PCS Coding System, please visit <http://www.cms.gov/Medicare/Coding/ICD10/index.html> on the CMS website.

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Related Change Request (CR) #: 6700

Related CR Release Date: November 6, 2009

Effective Date: April 1, 2010

Related CR Transmittal #: R5950TN

Implementation Date: April 5, 2010

**Note:** This article was updated on January 18, 2013, to reflect current Web addresses. All other information remains unchanged.

## Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility Stays

### Provider Types Affected

Skilled Nursing Facilities (SNFs) and ambulance suppliers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries should review this article.

### Provider Action Needed

This article is based on Change Request (CR) 6700 which implements additional Medicare system checks to ensure that ambulance services that are subject to Skilled Nursing Facility Consolidated Billing (SNF CB) rules (but that are billed separately as a Part B service) are denied when the date of service (DOS) on the

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ambulance claims overlap outpatient hospital claims that are rejected for SNF CB. SNF and ambulance billing staff should be aware of this issue.

## Background

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The Social Security Act (Section 1888(e); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1888.htm](http://www.ssa.gov/OP_Home/ssact/title18/1888.htm) on the Internet) established a Medicare prospective payment system (PPS) for skilled nursing facilities (SNF). 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 below). Accordingly, pursuant to the Social Security Act's consolidated billing (CB) requirements, SNFs are responsible for billing Medicare Part A for these services. The outside suppliers may not separately bill Medicare but must obtain payment from the SNFs.

A Department of Health and Human Services' Inspector General (IG) Report A-01-08-00505 dated August 25, 2009 (see <http://oig.hhs.gov/oas/reports/region1/10800505.asp> on the Internet); found that, on occasion, ambulance services that were subject to the SNF CB rule were improperly billed separately by the supplier. The IG Report stated in part:

"Federal regulations (42 CFR § 409.27(c)) state that the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay. Accordingly, when an ambulance supplier erroneously bills Medicare Part B for ambulance services included in the SNF's Part A consolidated billing payment, Medicare pays for the same service twice, once to the SNF and once to the ambulance supplier."

"The SNF consolidated billing requirement applies only to those services that are provided to a SNF resident. As a result, ambulance transportation that begins or ends beneficiaries' SNF stays is excluded from consolidated billing. Federal regulations (42 CFR § 411.15(p)(3)(iii)) also state that receiving certain emergency or intensive outpatient hospital services that are beyond a SNF's scope of care ends a beneficiary's status as a SNF resident. Accordingly, because the beneficiary receiving those specific emergency or intensive outpatient hospital services is temporarily not a SNF resident, ambulance transportation associated with those services is excluded from consolidated billing and may be billed to Medicare Part B."

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You can review 42 CFR 409.27(c) and 42 CFR 411.15(p)(3)(iii) at <http://www.gpo.gov/fdsys/> on the Internet.

As stated above, 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; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf> on the Centers for Medicare & Medicaid Service website), ambulance payments associated with the following outpatient hospital service exclusions are paid under the ambulance fee schedule:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRIs);
- Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital's gastrointestinal (GI) 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 PPS rate and **may not be billed as Part B services by the supplier**. In these scenarios, the services provided are subject to SNF CB:

- 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 Medicare Administrative Contractor (MAC) ;
- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility.

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

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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 CR 6700, Medicare will use 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).

Note also that 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.

## Additional Information

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The official instruction, CR 6700, issued to your Carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R5950TN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your Carrier, FI, or A/B MAC 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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