

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: SE0433 **Revised** Related Change Request (CR) #: NA

Related CR Release Date: NA Effective Date: NA

Related CR Transmittal #: NA Implementation Date: NA

Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services

Note: This article was revised on July 23, 2018, to add clarifying language in the Background section. All other information is unchanged.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers submitting claims to Medicare Administrative Contractors (MACs) should review this article.

Provider Action Needed

This Special Edition article describes SNF Consolidated Billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its MAC 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), which would submit the bill for Part B services to their MAC, as well as practitioners and suppliers who

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would generally submit their bills to a MAC. (Bills for certain types of items or equipment would be submitted by the supplier to their DME MAC.

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See MLN Matters® Article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf>.

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 (that is based on the reason the ambulance service is needed). This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, 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 events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- A trip to the beneficiary’s home to receive services from a Medicare-participating home health agency under a plan of care;
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that CMS has identified as being beyond the general scope of SNF comprehensive care plans (see further explanation below); or

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- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF before the following midnight.

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, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. (In the Part A MAC Update list of HCPCS codes affected by CB, such services are referred to as "Major Category I"). These services are the following:

- 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.

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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, as discussed further below) 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 an SNF resident in connection with receiving excluded Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

When an individual leaves a SNF via ambulance and does not return to that or another SNF before the following midnight, the day is not a covered Part A day and, accordingly, CB would not apply. However, 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 before the following midnight (see 42 CFR 411.15(p)(3)(iv)). Therefore, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 before the following midnight, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, a medically necessary ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under 42 CFR 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, it should be noted that in addition to the "medical necessity" criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient's medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient's condition. For example, a transfer between two SNFs would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, an SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.

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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 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)). Thus, 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.

Noncoverage 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 noncovered 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(g)(18), which require Medicare-participating SNFs to “. . . inform each resident before, or at the

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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/Medicaid or by the facility's per diem rate.”

Additional Information

See MLN Matters® Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf>.

The CMS MLN CB website is at

<http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the MAC (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 CB website is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSS/index.html>.

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).

Document History

- July 23, 2018 – Article revised to make clarifications in the Background section. All other information remains the same.

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- November 14, 2013 – Article revised to add clarifying language regarding "Transfers between Two SNFs". All other information remains the same.

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