CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4021	**Date: April 13, 2018**
	Change Request 10550

SUBJECT: Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A - Medicare Benefit Policy Manual, Chapter 10 and Medicare Claims Processing Manual, Chapter 15

I. SUMMARY OF CHANGES: This change request (CR) provides clarification on coverage of an ambulance transport for a SNF resident in stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF, including the return trip.

EFFECTIVE DATE: July 16, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 16, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/10.4/Additional Introductory Guidelines
R	15/30.2.2/SNF Billing

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4021	Date: April 13, 2018	Change Request: 10550

SUBJECT: Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A - Medicare Benefit Policy Manual, Chapter 10 and Medicare Claims Processing Manual, Chapter 15

EFFECTIVE DATE: July 16, 2018
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I. GENERAL INFORMATION

A. Background: This transmittal provides clarification on coverage of an ambulance transport for a SNF resident in a stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF including the return trip. The Centers for Medicare and Medicaid Services (CMS) is revising the Medicare Claims Processing Manual to clarify that a medically necessary ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B for a beneficiary who is in a SNF stay not covered by Part A, but who has Part B benefits. For example, this includes transport of such residents from the SNF (ambulance modifier N) to the nearest diagnostic or therapeutic site other than a physician's office or hospital such as an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, and wound care center as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

B. Policy: In the June 17, 1997 ambulance proposed rule (62 FR 32720), CMS proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is an inpatient, including the return trip. CMS finalized this proposal in the January 25, 1999 final rule (64 FR 3648) at 42 CFR 410.40 (e)(3). CMS is adding this policy to the Medicare Claims Processing Manual. If a beneficiary is residing in a SNF with Part B benefits and there is no coverage for the SNF services under Part A, a medically necessary ambulance transport to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. For example, this includes transport of such residents from the SNF (ambulance modifier N) to the nearest diagnostic or therapeutic site other than a physician's office or hospital such as an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, and wound care center as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10550 - 04.1	Contractors shall be aware of the changes to the Medicare Claims Processing Manual - Chapter 15, Sections 10.4 and 30.2.2.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10550 - 04.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information: N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Amy Gruber, amy.gruber@cms.hhs.gov , Teira Canty, teira.canty@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

10.4 - Additional Introductory Guidelines

(Rev.4021; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)

Since April 1, 2002 (the beginning of the transition to the full implementation of the ambulance fee schedule), payment for a medically necessary ambulance service is based on the level of service provided, not on the vehicle used.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. *(If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B. Also, if the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.)* Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.3.3 - Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service for further details. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling for additional information on hospital inpatient bundling of ambulance services. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing for the definitions of an inpatient for the various inpatient facility types. All Prospective Payment Systems (PPS) have a different criteria for determining when ambulance services are payable (i.e., during an interrupted stay, on date of admission and date of discharge).

NOTE: The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS, oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are NOT separately payable.

The A/B MAC (A) is responsible for the processing of claims for ambulance services furnished by a hospital based ambulance or for ambulance services provided by a supplier if provided under arrangements for an inpatient. The A/B MAC (B) is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. See section 10.2 below for further clarification of the definition of Providers and Suppliers of ambulance services.

Effective December 21, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a non-hospital-based dialysis facility, origin and destination modifier “J,” satisfy the program’s origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital or SNF are typically not billed by the supplier to its A/B MAC (B), but are billed by the provider to its A/B MAC (A).

The A/B MAC (A) is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the A/B MAC (B), the A/B MAC (B) has this responsibility, and the A/B MAC (A) shall contact the A/B MAC (B) to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the A/B MAC (A) should accept the A/B MAC (B)'s determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, if ambulance claims submitted with a code(s) that is/are not separately billable the payment for the code(s) is included in the base rate.

Contractors shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO
CARC: 97
RARC: N390
MSN: 1.6

This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

Payment for ambulance services may be made only on an assignment related basis.

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from Inherent Reasonableness provisions.

30.2.2 - SNF Billing

(Rev.4021; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)

When billing for ambulance transports of SNF residents, suppliers should indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier (e.g., "NH" for a transport from a SNF to a hospital). The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. For additional information, see Chapter 6, SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1, Ambulance Services. They may be billed as Part B services by the supplier only in the following situations:

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS code modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.)

- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS code ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date, and the SNF patient status (FL 22) is other than 30.)

- The ambulance trip *is to or from a hospital based or non-hospital based ESRD facility (either one of any HCPCS code ambulance modifiers is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility) and the other modifier is N (SNF)).*

- The ambulance trip is from the SNF to another SNF (the first and second character (origin and destination) of any ambulance HCPCS code modifier is "N" (SNF)) and the beneficiary is not in a Part A stay.

Ambulance payment associated with the following outpatient hospital service exclusions is 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.

See Chapter 6, § 20.1.2, Other Excluded Services Beyond the Scope of a SNF Part A Benefit, for further information pertaining to the list of services that are excluded from SNF Part A payment referenced above.

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. For additional information, see Chapter 6, § 20.3.1, In these scenarios, the services provided are subject to SNF CB and the first SNF is responsible for billing the services to the A/B MAC (A):

- Suppliers should bill with an "NN" origin/destination modifier when a *SNF-to-SNF transport occurs. A transport between two SNFs (that is, a beneficiary's same-day transfer from one SNF to another)* is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a *Part B* claim for such a transport.

Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy

center, wound care center, etc.). The first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (Diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is "N" (SNF). *Exception: An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.*