
CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 459

Date: FEBRUARY 4, 2005

CHANGE REQUEST 3676

NOTE: Transmittal 342, dated October 29, 2004, is rescinded and replaced with Transmittal 459, dated February 4, 2005. This is a correction to Change Request (CR) 3427, Transmittal 342, to correct the Business Requirements. All other information remains the same.

SUBJECT: Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site. Full Replacement of Change Request (CR) 3427, Transmittal 342, Issued on October 29, 2004

I. SUMMARY OF CHANGES: This instruction replaces CR 3427, Transmittal 342, issued on October 29, 2004. The business requirements incorrectly stated to reject claims containing revenue code 054x, in addition to an origin/destination modifier of “ND” or “DN”, when the beneficiary is in a covered Part A SNF stay. The language in the business requirements are revised to reject only line items containing revenue code 054x, in addition to an origin/destination modifier of “ND” or “DN”, when the beneficiary is in a covered Part A SNF stay. All other information remains the same.

NOTE: Programming hours have previously been assigned under CR 3427, therefore, this CR has no systems impact.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005

IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.)

(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|-------|----------------------------------|
| R | 6/20.3.1/Ambulance Services |
| R | 15/30.2.3/SNF Billing |
| | |

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

| | |
|----------|--------------------------------------|
| X | Business Requirements |
| X | Manual Instruction |
| | Confidential Requirements |
| | One-Time Notification |
| | Recurring Update Notification |

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Business Requirements

| | | | |
|-------------|------------------|------------------------|----------------------|
| Pub. 100-04 | Transmittal: 459 | Date: February 4, 2005 | Change Request: 3676 |
|-------------|------------------|------------------------|----------------------|

NOTE: Transmittal 342, dated October 29, 2004, is rescinded and replaced with Transmittal 459, dated February 4, 2005. This is a correction to Change Request (CR) 3427, Transmittal 342, to correct the Business Requirements. All other information remains the same.

SUBJECT: Full Replacement of Change Request (CR) 3427, Transmittal 342, Issued on October 29, 2004- Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site.

I. GENERAL INFORMATION

A. Background: In CR 3427, Transmittal 342, issued on October 29, 2004, Section II of the Attachment – Business Requirements incorrectly stated to reject claims containing revenue code 054x, in addition to an origin/destination modifier of “ND” or “DN” when the beneficiary is in a covered Part A SNF stay. The language in the business requirements are revised to reject only line items containing revenue code 054x, in addition to an origin/destination modifier of “ND” or DN, when the beneficiary is in a covered Part A SNF stay. All other information remains the same.

NOTE: Programming hours have previously been assigned under CR 3427, therefore, this CR has no systems impact.

Section 4432(b) of the Balanced Budget Act (BBA) requires consolidated billing (CB) for Skilled Nursing Facilities (SNF). Under the CB requirement, the SNF must submit all Medicare claims for all the services its residents receive under Part A (except for certain excluded services). In addition, the SNF must also submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents receive under inpatient Part B. All Medicare-covered Part A services that are deemed to be within a SNF’s scope or capability are considered paid in the SNF PPS rate.

Except for specific exclusions, SNF CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay.

Ambulance transports to or from an independent diagnostic testing facility (IDTF) are considered paid in the SNF PPS rate when the beneficiary is in a covered Part A stay and may **not** be paid separately as Part B services. The ambulance transport is included in the SNF PPS rate if 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). In this instance, the SNF is responsible for the costs of the transport. The “D” origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers, and all other diagnostic or therapeutic sites.

Note: Ambulance transports to and from renal dialysis facilities for the purpose of receiving dialysis are excluded from SNF CB. In this case, the first or second character (origin or destination) of any HCPCS code ambulance modifier is a “G” (Hospital based ESRD facility) or “J” (Freestanding ESRD facility),

| Requirement Number | Requirements | Responsibility (“X” indicates the columns that apply) | | | | | | | | |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------|---------------------------------|-----------------------|---------------------------|-------------|-------------|-------------|-------|
| | | F I | R H I | C a r r i e r | D M E R C | Shared System Maintainers | | | | Other |
| | | | | | | F I S S | M C S | V M S | C W F | |
| | an origin/destination modifier of "ND" or "DN" when the beneficiary is in a covered Part A SNF stay. | | | | | | | | | |
| 3676.3 | Effective for claims with dates of service on or after April 1, 2005, the FIs and their SSM shall reject line items containing revenue code 054x, ambulance services, billed by institutional providers for a beneficiary in a covered Part A SNF stay being transported to or from an IDTF, or other diagnostic or therapeutic site. 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). The provider of service for the ambulance transport must look to the SNF for payment. The SNF is responsible for payment. | X | | | | X | | | | |
| 3676.4 | FIs shall use MSN message 13.9: “Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date,” when rejecting line items for ambulance transports between a SNF and an IDTF, or other diagnostic or therapeutic sites. 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). | X | | | | X | | | | |
| 3676.5 | FIs shall use ANSI Reason code 97: “Payment is included in the allowance for another service/procedure,” on the remittance advice when rejecting line items for ambulance transports to or from an IDTF, or other diagnostic or therapeutic site. The first or second character (origin or destination) of any HCPCS code ambulance modifier is “D” | X | | | | X | | | | |

| Requirement Number | Requirements | Responsibility (“X” indicates the columns that apply) | | | | | | | |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------|---------------------------------|-----------------------|---------------------------|-------------|--|--|
| | | F I | R H I | C a r r i e r | D M E R C | Shared System Maintainers | | | |
| F I S S | M C S | | | | | V M S | C W F | | |
| | (Diagnostic or therapeutic site other than P or H) and the other modifier (origin or destination) is “N” (SNF). | | | | | | | | |
| 3676.6 | FIs shall use Remittance Advice 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,” when rejecting line items for ambulance transports between a SNF and an IDTF, or other diagnostic or therapeutic site. 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). | X | | | | X | | | |

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

| X-Ref Requirement # | Instructions |
|---------------------|--------------|
| N/A | |

B. Design Considerations:

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---------------------|-------------------------------------------------|
| N/A | |

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <p>Effective Date*: April 1, 2005</p> <p>Implementation Date: April 4, 2005</p> <p>Pre-Implementation Contact(s): Jason Kerr (410) 786-2123 or JKerr3@cms.hhs.gov ; Yvonne Young (410) 786-1886 or YYoung@cms.hhs.gov (for FI related issues)</p> <p>Post-Implementation Contact(s): Appropriate Regional Office</p> | <p>Medicare contractors shall implement these instructions within their current operating budgets.</p> |
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***Unless otherwise specified, the effective date is the date of service.**

20.3.1. - Ambulance Services

(Rev. 459, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. Carriers *and intermediaries* are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier *or intermediary (as appropriate)* directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS 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 after discharge, to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care (the first character (origin) of any HCPCS ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date and the SNF patient status is other than 30;
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility) for the purpose of receiving dialysis and related services excluded from consolidated billing;
- The ambulance trip is from the SNF to a Medicare participating hospital or a CAH for an inpatient admission;
- The ambulance trip after a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services.

Note that ambulance trips associated with services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing. *The first or second character (origin or destination) of any HCPCS code ambulance modifier is “G” (hospital-based dialysis facility), or “J” (non hospital-based dialysis facility), and the other modifier (origin or destination) is “N” (SNF).* Effective April 1, 2002, payment shall be the amount prescribed in the ambulance fee schedule.

The following ambulance services are included in SNF CB and may ***not*** be billed as Part B services to the intermediary or carrier when the beneficiary is in a Part A stay:

- A beneficiary’s transfer from one SNF to another before midnight of the same day.
- 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 ambulance transport is included in the SNF PPS rate if 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).* The first SNF is responsible for billing the services to the FI.

See Chapter 15 for Ambulance Services.

30.2.3 - SNF Billing

(Rev. 459, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. 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 a hospital based or nonhospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Nonhospital based dialysis facility)).
- 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;
- Emergency services;
- Angiography;
- Lymphatic and Venous Procedures; and
- Radiology therapy.

Finally, ambulance transportation for removal, replacement, and insertion of PEG tubes is an excluded service under consolidated billing for Part A and is not considered an SNF service. Therefore, that ambulance is also excluded from SNF consolidated billing (CB), and the service would be billed to the carrier under Part B.

When not subject to SNF CB, claims for drugs and EKG testing administered during a transport to or from a SNF are separately payable during the AFS transition period only in those carrier jurisdictions that allowed separate payment for J-codes and EKG testing prior to the implementation of the AFS. (Only Method 3 and Method 4 suppliers in

carrier jurisdictions that allowed separate payment for these services prior to April 1, 2002 may bill separately for J-codes and EKG testing during the transition period.)

Carriers in those jurisdictions that allow separate billing for J-codes and EKG testing apply the appropriate reasonable charge percentage for the AFS transition year (40% in 2004) to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the fee schedule, there is no FS portion for these codes.) In jurisdictions where separate payment for J-codes and EKG testing was not permitted prior to April 1, 2002, carriers shall deny supplier claims for such services.

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 and the first SNF is responsible for billing the services to the intermediary:

- A beneficiary's transfer from one SNF to another before midnight of the same day. The first and second characters (origin and destination) of any HCPCS code ambulance modifier are "N" (SNF).
- A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport. When billing for ambulance transports, 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).
- Suppliers should bill with an "NN" origin/destination modifier when a SNF to SNF transport occurs. A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a 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).