CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3620	**Date: October 7, 2016**
	Change Request 9791

SUBJECT: Update to Pub 100-04, Medicare Claims Processing Manual, Chapter 15: Ambulance

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update Chapter 15 with information pertaining to the Skilled Nursing Facility Prospective Payment System (PPS) and consolidated billing (CB).

EFFECTIVE DATE: November 8, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 8, 2016
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	15/30.2.2/ 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: 3620	Date: October 7, 2016	Change Request: 9791

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I. GENERAL INFORMATION

A. Background: Chapter 15, section 30.2.2 of the Medicare Claims Processing Manual, is being revised to include additional information pertaining to Skilled Nursing Facility Prospective Payment System (PPS) and consolidated billing (CB).

B. Policy: This CR contains no policy changes. Contractors shall note the updates to the manual section.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9791.1	Contractors shall be in compliance with the instructions found in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 15-Ambulance, section 30.2.2	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): 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):
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ATTACHMENTS: 0

30.2.2 - SNF Billing

(Rev.3620; Issued: 10-07-16; Effective: 11-08-16, Implementation: 11-08-16)

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 a hospital based or non-hospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital 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, 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):

- 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.

o 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).