| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 595** | **Date: November 6, 2009** |
| | **Change Request 6700** |

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

**I. SUMMARY OF CHANGES:** An Inspector General Draft Report (A-01-08-00505 dated July 1, 2009) found that, on occasion, ambulance services that should have been paid for under the SNF Consolidated Billing rules were instead paid for separately under Part B. This change request instructs the contractors to deny any claims for Part B ambulance services when such services should be paid under the SNF consolidated billing rules.

**New / Revised Material**
**Effective Date: April 1, 2010**
**Implementation Date: April 5, 2010**

*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 |
|---|---|
| N/A | |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:**

**One-Time Notification**

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

# Attachment – One-Time Notification

| Pub. 100-20 | Transmittal: 595 | Date: November 6, 2009 | Change Request: 6700 |
|---|---|---|---|

**SUBJECT: Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility Stays.**

**Effective Date**: April 1, 2010

**Implementation Date:** April 5, 2010

## I. GENERAL INFORMATION

**A. Background:** Section 1888(e) of the Social Security Act (the Act) 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 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.

An Inspector General Draft Report (A-01-08-00505 dated July 1, 2009) found that, on occasion, ambulance services that were subject to the SNF Consolidated Billing rule were improperly billed separately by the supplier. It 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 ambulances 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."

As stated from 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 Internet Only Manual 100-04 Chapter 15 § 30.2.2, 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.

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 A/MAC: 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.

This CR will implement additional 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 DOS on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB.

**B. Policy:** The claims processing system shall enforce SNF CB rules by subjecting claims for ambulance services to the following conventions. If a claim for a hospital outpatient service is denied because it should have been billed and paid for according to SNF CB rules, contractors shall deny any ambulance service associated with the denied hospital outpatient service as the ambulance transportation is also subject to SNF CB rules. 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.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6700.1 | Contractors shall create a new claim level reject edit to be assigned when all line items are rejected by the CWF for SNF CB edits. | | | | | | X | | | | |
| 6700.1.1 | Contractors shall ensure that Claim Adjustment Reason Code 190 – "Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay" is assigned by the FISS when all line items reported on a claim are rejected by the CWF for SNF CB. | X | | X | | | X | | | | |
| 6700.1.2 | Contractors shall ensure that rejected claims from 6700.1 are sent to the CWF file claims history with an "N" – "All other reasons for non-payment" in the Non Payment Code field. | X | | X | | | X | | | | |
| 6700.2 | CWF shall reject for SNF CB an incoming supplier ambulance claim with specialty code 59 containing a detail line item DOS that equals the From date of a previously processed claim with TOBs 130 or 850 and claim adjustment reason code 190 found in the ANSI transmit information. | | | | | | | | | X | |
| 6700.2.1 | Contractors shall use the following remittance advice/MSN messages to deny incoming ambulance supplier claims when the contractor receives the CWF rejection from BR 6700.2: | X | | | X | | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | Reason Code 190 – Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.<br><br>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.<br><br>Group Code CO – Contractual Obligation<br><br>MSN Message 13.10 – Medicare Part B does not pay for items or services provided by this type of practitioner since our records show that you were receiving Medicare benefits in a skilled nursing facility on this date. | | | | | | | | | | |
| 6700.3 | CWF shall generate an Informational Unsolicited Response (IUR) for previously processed supplier claims with specialty code 59 where the detail line item DOS equals the From date on an incoming claim with TOBs 130 or 850 and claim adjustment reason code 190. | | | | | | | | | X | |
| 6700.3.1 | Contractors shall, upon receipt of the IUR, initiate overpayment recovery procedures, and generate an adjustment to update or cancel the claim in order to update CWF history. | X | | | X | | | | | | |

**III. PROVIDER EDUCATION TABLE**

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6700.4 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly | X | | X | X | | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | 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. | | | | | | | | | | |

## IV. SUPPORTING INFORMATION

**Section A:**
*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 6700.1 | Contractors shall note this includes claim level reason codes 10415, 10416 and any other applicable claim level reason codes assigned by FISS for claims with all line items rejected for SNF CB. |

**Section B: N/A**

## V. CONTACTS

**Pre-Implementation Contact(s):** For questions pertaining to FISS and Part A claims processing instructions, contact Jason Kerr at (410) 786-2123 or Jason.Kerr@cms.hhs.gov. For questions pertaining to MCS and Part B claims processing instructions, contact Eric Coulson at (410) 786-3352 or Eric.Coulson@cms.hhs.gov.

**Post-Implementation Contact(s):** For questions pertaining to SNF consolidated billing, contact Jason Kerr at (410) 786-2123 or Jason.Kerr@cms.hhs.gov. For questions pertaining to the processing of claims for institutionally-based ambulance services, contact Valeri Ritter at (410)786-8652 or Valeri.Ritter@cms.hhs.gov. For questions pertaining to the processing of claims for ambulance suppliers, contact Eric Coulson at (410)786-3352 or Eric.Coulson@cms.hhs.gov.

## VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *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.