



## Revision of SNF CB Edits for Ambulance Services Rendered to Beneficiaries in a Part A Skilled Nursing Facility Stay

MLN Matters Number: MM10955

Related Change Request (CR) Number: 10955

Related CR Release Date: November 2, 2018

Effective Date: April 1, 2019

Related CR Transmittal Number: R2176OTN

Implementation Date: April 1, 2019

### PROVIDER TYPES AFFECTED

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This MLN Matters Article is intended for, Skilled Nursing Facilities (SNFs) and ambulance providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

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Change Request (CR) 10955 revises the SNF Consolidated Billing (CB) edits to ensure accurate payment of ambulance services rendered to beneficiaries in a covered Part A SNF stay. CR10955 does not contain any new policy and only further revises existing claim system edits to ensure accurate payment of ambulance transports that are included in or excluded from SNF CB. Make sure your billing staffs are aware of these revisions.

### BACKGROUND

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CR6700 (Transmittal 595, issued Nov. 6, 2009) implemented certain claim system edits intended to deny claims for Part B ambulance services that should be bundled under SNF CB rules. In 2017, the Inspector General conducted a follow-up audit of Medicare payments for Part B ambulance services furnished to beneficiaries in a Part A covered SNF stay. The Inspector General found that the current claim system editing is insufficient to prevent overpayments to ambulance providers and suppliers for transports that should have been bundled under SNF CB.

Generally, ambulance services are bundled when furnished to a beneficiary who has the status of a SNF “resident” for CB purposes. This general principle is one that the SNF PPS basically inherited from the Inpatient Prospective Payment System (IPPS), which has a similar rule for hospital bundling of ambulance transports.

One exception to this general SNF CB rule on ambulance services is when such transports are furnished in connection with the receipt of offsite Part B dialysis services. Even though the receipt of offsite dialysis doesn’t affect the beneficiary’s SNF “resident” status, dialysis-related

ambulance services are nevertheless excluded from CB per Section 103 of the Balanced Budget Refinement Act (BBRA) of 1999, which amended Section 1888(e)(2)(A)(iii)(I) of the Social Security Act (the Act) specifically to carve out dialysis-related ambulance transports from the SNF CB bundle.

Under the general rule set forth above, the initial ambulance trip that first brings a beneficiary to the SNF is not subject to CB because the beneficiary has not yet been admitted to the SNF as a resident at that point. Similarly, an ambulance transport 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 following events specified in subclauses (i) through (iv) of 42 CFR 411.15(p)(3) as ending the beneficiary's SNF "resident" status:

- A trip for an inpatient admission to a Medicare-participating hospital or Critical Access Hospital (CAH)
  - Note: See the discussion below on "Transfers Between Two SNFs," regarding an ambulance trip that conveys a beneficiary from the discharging SNF for a same-day inpatient admission to 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 exceptionally intensive outpatient services (Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, cardiac catheterizations, ambulatory surgery that requires the use of an operating room or comparable facilities, and so forth) that the Centers for Medicare & Medicaid Services (CMS) has designated as being beyond the general scope of SNF comprehensive care plans
- A formal discharge (or other departure) from the SNF, unless the beneficiary returns to that or another SNF before the following midnight.

**Transfers Between Two SNFs:** When a beneficiary is discharged from a covered stay in SNF 1 and then transfers to SNF 2 before the following midnight, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under Section 411.15(p)(3)(i), 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. By contrast, when an individual leaves an 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. Accordingly, CB would not apply to that ambulance trip.

**Roundtrip to Physician's Office:** Confusion sometimes arises over the issue of an ambulance roundtrip that transports a SNF resident to a physician's office, since this is a type of destination that the Part B ambulance benefit doesn't normally cover. It's important to note that the regulations at 42 CFR 409.27(c) on coverage of ambulance transports under the SNF benefit provide that such transports must meet the general medical necessity requirement, described in 42 CFR 410.40(d)(1), that applies under the separate Part B ambulance benefit (that is, the beneficiary's condition must be such that transportation by any means other than ambulance would be medically contraindicated). However, while the Part A SNF regulations incorporate this

general requirement, they don't incorporate the more detailed coverage restrictions that apply to the Part B ambulance benefit—such as the limitation of coverage under Part B to include only those trips that transport a beneficiary to certain specified destinations (42 CFR 410.40(e)). Thus, 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 (using any other means of transport would be medically contraindicated), then the ambulance roundtrip is subject to CB and included in the SNF bundle.

**Non-ambulance Forms of Transport:** In contrast to the ambulance coverage discussed above, Medicare simply doesn't provide any coverage at all – under Part A or B – for any *non-ambulance* forms of transportation, such as ambulette, wheelchair van, or litter van. Thus, in those situations where it's medically feasible to convey a SNF resident by some means other than an ambulance, the transportation of such a resident (regardless of the type of vehicle used) would neither be included within the SNF bundle nor coverable under the separate Part B ambulance benefit but would simply be altogether noncovered by Medicare. As with any other noncovered service for which a resident may be financially liable, the SNF is required under the regulations at 42 CFR 483.10(g)(18) to, “ ... inform each resident before, or at the 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 and/or Medicaid, or by the facility's per diem rate.”

## ADDITIONAL INFORMATION

The official instruction, CR10955, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2176OTN.pdf>.

You may want to review MLN Matters Article SE0433 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se0433.pdf> for more details. An article related to CR6700 is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6700.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

## DOCUMENT HISTORY

Date of Change	Description
November 2, 2018	Initial article released.

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