CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2176	**Date: November 2, 2018**
	Change Request 10955

SUBJECT: Revision of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Services Rendered to Beneficiaries in a Part A SNF Stay

I. SUMMARY OF CHANGES: This Change Request (CR) revises the SNF CB edits to ensure accurate payment of ambulance services rendered to beneficiaries in a covered Part A SNF stay.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

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	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2176	Date: November 2, 2018	Change Request: 10955

SUBJECT: Revision of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Services Rendered to Beneficiaries in a Part A SNF Stay

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I. GENERAL INFORMATION

A. Background: Change Request (CR) 6700 (Transmittal 595, issued November 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 Prospective Payment System (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 §103 of the Balanced Budget Refinement Act 1999, which amended §1888(e)(2)(A)(iii)(I) of the Social Security Act specifically to carve out dialysis-related ambulance transports from the SNF 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, etc.) that CMS has designated as being beyond the general scope of SNF comprehensive care plans; or
- 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 §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 (i.e., 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 an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., 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* Part 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 actually 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/Medicaid or by the facility's per diem rate."

B. Policy: No new policy. This CR will further revise existing claim system edits to ensure accurate payment of ambulance transports that are included in or excluded from SNF CB.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10955.1	The Common Working File (CWF) shall modify existing SNF CB edit 7275 and the associated Informational Unsolicited Response (IUR) (if necessary) to reject incoming ambulance supplier and provider claim lines when the following occurs:								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Incoming provider or supplier ambulance claim contains: Specialty code '59' (for Part B claims) or Revenue code 054x (for Outpatient claims) ; and • Beneficiary is in a SNF Part A covered stay; and • No outpatient hospital claim (13X or 85X) in history OR there is no paid or denied outpatient hospital claim (13X or 85X) in history containing at least one Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code from a category of service which excludes ambulance from SNF consolidated billing NOTE: CWF should use existing tables containing services excluded from SNF consolidated billing.									
10955.2	CWF shall modify existing SNF CB edit(s) as necessary to ensure that incoming ambulance claim lines containing any of the following modifier(s) are rejected when the beneficiary is in a SNF Part A covered stay: NP, PN, NN, ND, or DN.								X	
10955.2.1	Upon receipt of the CWF rejection, A/B MACs (Part A) shall reject and A/B MACs (Part B) shall deny the incoming ambulance claim, as appropriate, using the existing Claim Adjustment Reason Code/Remittance Advice Remark Codes (CARC/RARC) and Medicare Summary Notice (MSN) messages for the modified SNF CB edit.	X	X							
10955.3	CWF shall modify existing SNF CB edit 7275 as necessary to bypass the edit for incoming ambulance claim lines containing any of the following modifier(s) when the beneficiary is in a SNF Part A covered stay: NG, GN, NJ, or JN.								X	
10955.4	CWF shall modify existing SNF CB edit(s) 7275 as necessary to bypass the edit(s) for incoming ambulance claims containing modifier NH or HN only if there is an outpatient hospital claim in history (paid or denied) with the same Date of Service (DOS) containing a HCPCS/CPT code from one of the								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	following categories of service that are excluded from SNF CB: • Cardiac catheterization • CT scans • MRI services • Ambulatory surgery involving the use of an operating room (including insertion of Percutaneous Esophageal Gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite) • Emergency room services • Radiation therapy • Angiography • Lymphatic and venous procedures NOTE: CWF should leverage existing bypass condition logic in other SNF CB edits.									
10955.4.1	CWF shall reject the incoming ambulance claim if the outpatient claim in history does NOT contain a HCPCS/CPT code from one of the categories of service that are excluded from SNF CB.								X	
10955.4.2	Upon receipt of the CWF rejection, the A/B MACs (Part A) shall reject and A/B MACs (Part B) shall deny the incoming ambulance claim using the existing CARC/RARC and MSN messages for the modified SNF CB edit.	X	X							
10955.5	CWF shall modify the existing IUR for edit 7275 to identify rejected ambulance claims in history upon receipt of an incoming outpatient hospital claim containing a HCPCS/CPT code from one of the categories of service identified in requirement 4. NOTE: Upon receipt of the IUR, the SSMs shall continue to systematically adjust the previously rejected (Part A provider) or denied (Part B supplier) ambulance claim.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10955.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
2,3,4	Refer to MLN Matters article SE0433
1	The set parameters for CWF edit 7275 and the associated IUR currently require that the outpatient hospital claim be TOB 130. This requirement is intended to modify the parameter to apply to outpatient hospital claims with TOB 13X or 85X and require that the outpatient hospital claim include at least one service excluded from SNF CB.

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

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe, felicia.rowe@cms.hhs.gov , Valerie Ritter, valerie.ritter@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