

---

# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

---

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

Transmittal 163

Date: April 30, 2004

---

### CHANGE REQUEST 3196

**I. SUMMARY OF CHANGES:** This transmittal implements a change to the processing of Skilled Nursing Facility (SNF) claims for ambulance transports of a beneficiary in a Part A stay to or from a diagnostic or therapeutic site other than a physician's office or hospital when billed separately as Part B services to the carrier. The transmittal also incorporates into the manual the SNF consolidated billing rules applicable to ambulance transports that have been conveyed in previous issuances, and makes a technical correction to the manual.

**NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004**

**\*IMPLEMENTATION DATE: October 4, 2004**

*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: (R = REVISED, N = NEW, D = DELETED)**

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

**\*III. FUNDING:**

**These instructions shall be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

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

**\*Medicare contractors only**

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 163	Date: April 30, 2004	Change Request 3196
-------------	------------------	----------------------	---------------------

**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 Other than a Physician's Office or Hospital**

## I. GENERAL INFORMATION

### A. Background:

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing (CB) for SNFs. Under the CB requirement, the SNF must submit all Medicare claims for all the services that its residents receive under Part A, except for certain excluded services, and for all physical, occupational, and speech-language pathology services received by residents under Part B. All Medicare-covered Part A services that are considered within the scope or capability of SNFs are considered paid in the SNF prospective payment system (PPS) rate.

### B. Policy:

Except for specific exclusions, SNF CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. Carriers are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

Ambulance transports to or from a diagnostic or therapeutic site other than a physician's office or hospital (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center) are considered paid at the SNF PPS rate when the beneficiary is in a Part A stay and may not be paid separately as Part B services when billed to the carrier. See Section 30.2.3 of the Medicare Claims Processing Manual, Chapter 15, "Ambulance" for the complete set of SNF CB rules applicable to ambulance transports.

**C. Provider Education:** A provider education article related to this instruction will be available at [www.cms.hhs.gov/medlearn/matters](http://www.cms.hhs.gov/medlearn/matters) shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. 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 must be included in your next regularly scheduled bulletin.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*

*"Should" denotes an optional requirement*

<b>Requirement #</b>	<b>Requirements</b>	<b>Responsibility</b>
3196.1	Effective October 4, 2004, the CWF System Maintainer shall create an edit to deny Part B ambulance specialty type “59” claims with an origin/destination modifier of “ND” or “DN” when the beneficiary is in a Part A stay.	CWF System Maintainer
3196.2	Effective October 4, 2004, the CWF System Maintainer shall add to the unsolicited process the edit logic for rejecting Part B ambulance specialty type “59” claims with an origin/destination modifier of “ND” or “DN” when the beneficiary is in a Part A.	CWF System Maintainer
3196.3	Effective for claims with dates of service on or after October 4, 2004, the carrier shall deny supplier Part B claims for SNF ambulance transports to or from a diagnostic or therapeutic site other than a physician’s office or hospital (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.) when the beneficiary is in a Part A stay. The first or second character (origin or destination) of any HCPCS code ambulance modifier is “D”, and the other modifier (origin or destination) is “N” (SNF).	Local Part B Carriers

### **III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

#### **A. Other Instructions: N/A**

<b>X-Ref Requirement #</b>	<b>Instructions</b>

#### **B. Design Considerations: N/A**

<b>X-Ref Requirement #</b>	<b>Recommendation for Medicare System Requirements</b>

#### **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**

<p><b>Effective Date:</b> October 1, 2004</p> <p><b>Implementation Date:</b> October 4, 2004</p> <p><b>Pre-Implementation Contact(s):</b> Susan Webster (410) 786-3384</p> <p><b>Post-Implementation Contact(s):</b> Susan Webster (410) 786-3384</p>	<p><b>These instructions shall be implemented within your current operating budget.</b></p>
---	---

## **20.3.1. - Ambulance Services**

*(Rev.163, 4-30-04 )*

### **SNF-516.2**

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 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 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. Effective April 1, 2002, payment shall be the amount prescribed in the ambulance fee schedule.

**NOTE:** A beneficiary's transfer from one SNF to another before midnight of the same day, *and ambulance transports to or from a diagnostic or therapeutic site other than a physician's office or hospital (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center), are* not excluded from consolidated billing. The first SNF is responsible for billing the services to the FI.

See Chapter 15 for Ambulance Services.

### **30.2.3 - SNF Billing**

*(Rev.163, 4-30-04 )*

#### **SNF-516.2, SNF QA Day4**

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the PPS rate. They may be billed as Part B services by the supplier in only 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 associated with the following *outpatient* hospital service exclusions payment is 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 physician's office or hospital (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", and the other modifier (origin or destination) is "N" (SNF).*