

## FACT SHEET REGARDING CONSOLIDATED BILLING AND AMBULANCE SERVICES

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### Fact sheet regarding Consolidated Billing and ambulance services

- The consolidated billing provision places with the SNF itself the Medicare billing responsibility for virtually all services furnished to a resident of the SNF during the course of a covered Part A stay that is paid under the Prospective Payment System (PPS). The only types of services furnished to SNF residents that are categorically excluded from consolidated billing are the ones specified in a short list of statutory exclusions at section 1888(e)(2)(A)(ii)-(iii) of the Social Security Act (the Act), for which an outside supplier can still bill Medicare directly and receive a separate payment.
- Since ambulance services (other than those furnished in conjunction with the receipt of Part B dialysis services--see section 1888(e)(2)(A)(iii)(I) of the Act) do not appear on this statutory excluded list, they are subject to consolidated billing when furnished to an SNF "resident" (see below) during the course of a covered Part A SNF stay, and are included in the PPS payment that Part A makes to the SNF. Excluding such ambulance services from the PPS and consolidated billing provisions would require legislation to amend the law.
- 1998 SNF PPS Interim Final Rule: The preamble to the 5/12/98 SNF PPS interim final rule (63 FR 26298) clarifies that under the consolidated billing provision, an ambulance trip is considered to be furnished to an SNF "resident" if it occurs during the course of an SNF stay, but not if it occurs at either the very beginning or end of the stay. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement for almost two decades.
- As explained in the preamble, the initial ambulance trip that first brings a beneficiary to an SNF is not subject to consolidated billing, since the beneficiary has not yet been admitted to the SNF as a resident at that point. Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to consolidated billing when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status:
  - + A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (however, see discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at 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 intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below); or
- + A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.
- Ambulance trips to receive excluded outpatient hospital services: As noted above, the regulations specify the receipt of certain exceptionally intensive or emergent services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for consolidated billing purposes. Such outpatient hospital services are themselves excluded from the consolidated billing requirement, on the basis of their being well beyond the typical scope of the SNF care plan. (However, the exclusion of a particular outpatient hospital service is not invoked on this basis merely because it does not appear in the *individual* SNF care plan of the person receiving the service; rather, the exclusion applies only to those specified categories of services that, by definition, lie well beyond the scope of SNF care plans *generally*).
- + Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum No. A-98-37 (November 1998, reissued as PM No. A-00-01, January 2000) are excluded from consolidated billing on this basis: cardiac catheterization; computerized axial tomography (CT) scans; magnetic resonance imaging (MRIs); ambulatory surgery involving the use of an operating room; emergency room services; radiation therapy; angiography; and, lymphatic and venous procedures.
- + Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for consolidated billing purposes, any associated ambulance trips are themselves excluded from consolidated billing as well; thus, an ambulance trip furnished in connection with the receipt of such services can still be billed separately to Part B by the outside supplier.
- + By contrast, when a beneficiary leaves the SNF to receive outpatient hospital services *other than* the excluded types of services described above and then returns to the SNF, he or she retains the status of an SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to consolidated billing, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is itself categorically excluded from the consolidated billing requirement.

- Transfers Between Two SNFs: Under the regulations at 42 CFR 411.15(p)(3)(iv), a beneficiary's departure from an SNF is not considered to be a "final" departure for consolidated billing purposes if he or she is readmitted to that or another SNF by midnight of the same day. Such a beneficiary continues to be considered a resident of the SNF from which he or she departed until the occurrence of one of the events specified as terminating the beneficiary's "resident" status. §411.15(p)(3)(i) specifies the admission to a second SNF as an event that ends a beneficiary's status as a "resident" of the first SNF. As discussed previously, consolidated billing applies only to services that are furnished during the course of a covered Part A stay that is paid under the PPS. Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which consolidated billing applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for consolidated billing 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 by midnight, the day is not a covered Part A day; accordingly, consolidated billing would not apply.
- 1999 SNF PPS Final Rule: The preamble to the SNF PPS final rule (64 FR 41672-75, July 30, 1999) clarifies that the scope of coverage under the Part A SNF benefit includes transportation via ambulance in situations meeting the general medical necessity requirements (as set forth in 42 CFR 410.40(d)(1)) that would apply to Part B coverage under the separate ambulance services benefit if the services were not covered under Part A; i.e., those situations in which a beneficiary's medical condition is such that other means of transportation would be contraindicated. In those situations that do not contraindicate the use of other, non-ambulance modes of transportation to obtain services from offsite sources, the preamble indicates that the facility's fundamental obligation is to ensure that each resident receives those services needed to attain or maintain the resident's "...highest practicable physical, mental, and psychosocial well-being" in accordance with regulations at 42 CFR 483.25. In fulfilling this basic obligation, however, an SNF may utilize a wide variety of means either to send its residents to the offsite location of the services or, alternatively, to bring the services themselves onsite to its residents.
  - + Moreover, in contrast to ambulance trips (for which a specific Part B benefit exists), there is no Part B benefit that provides coverage for non-ambulance forms of transportation. Further, SNFs historically have only rarely, if ever, directly undertaken to provide non-ambulance forms of transportation to their residents as part of a covered Part A stay. While in theory, the pre-PPS procedures for SNF cost reporting and payment under Part A could have recognized the costs incurred if SNFs had elected to undertake this function themselves, SNFs were in fact under no obligation to do so, and in actual practice, the responsibility for providing such transportation for SNF residents has generally been assumed instead by other sources, such as the Medicaid program, local community service organizations, or the resident's own family.

- + In this context, the preamble to the final rule explains that it is not our intent to include within the scope of the current SNF PPS bundle any types of transportation services for which the Medicare program did not previously assume financial responsibility under either Part A or Part B. Accordingly, the final rule clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

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