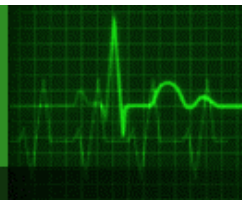




Vital Signs

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Consolidated Billing and PPS

The **Council** receives many questions from members throughout the year about Consolidated Billing (CB). On January 7, 2009 the Centers for Medicare and Medicaid Services (CMS) revised a MedLearn Matters article that reviewed consolidated billing and ambulance services as they apply to Consolidated Billing. This month's Vital Signs will review this important topic again, based on the latest MedLearn Matters update.

Excluded Services

In general, the following services are categorically excluded from consolidated billing:

- Physician Services furnished to SNF residents. These services are not subject to CB and thus are still billed separately to the Part B carrier.
- Certain diagnostic services include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to SNF CB. The technical component of these services must be billed to and reimbursed by the SNF. MedLearn Matters Article SE0440 has more detailed information on these diagnostic tests.
- Physician assistants working under a physician's supervision.
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician, who are not employed by the SNF.
- Certified registered nurse anesthetists
- Dialysis and dialysis related services to beneficiaries with ESRD and the administration of Epoetin alfa (Epogen) and Darbepoetin Alfa (Aranesp) for anemia in ESRD beneficiaries.
- Hospice Care for beneficiaries with terminal illness.

CMS also identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. The excluded service categories include:

- Cardiac catheterizations
- Computerized Axial Tomography Imaging (CT scans)
- Magnetic Resonance Imaging (MRI)
- Ambulatory surgeries involving the use of a hospital operating room
- Radiation therapy services
- Angiographies, and certain lymphatic and venous procedures
- Emergency services

There are additional exclusions for individual services within a number of broader service categories that otherwise remain subject to CB. There are specific HCPCS codes for these items. **Make sure you check the code for items in these categories. Do not presume that they are excluded just because they are part of the following group. They must have the appropriate code to be excluded.**

- Chemotherapy items and their administration
- Radioisotope services
- Customized prosthetic devices

Excluded Ambulance Services

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. According to CMS,

- *Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as 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 CB when it occurs in connection with one of the following events ending the beneficiary’s SNF “resident” status:*
 - *A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH)*
 - *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 other side for list.*

Since a beneficiary’s departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary’s status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary’s SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, 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 CB requirement.

Transfers Between Two SNFs

A beneficiary’s departure from an SNF is not considered to be a “final” departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day. The ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since 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. However, 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 and, accordingly, CB would not apply.

Roundtrip to a Physician’s Office

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 the responsibility of the SNF and is included in the PPS rate.

Noncoverage of Transportation by Any Means Other Than Ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not 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. This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance—for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation).