Q1. We provide outpatient services to SNF patients who are brought to our hospital and returned to the SNF via an ambulance. We send claims to Medicare for the patient’s outpatient service and it was rejected stating that it overlapped the SNF services. When we billed the SNF, they responded that it is not part of SNF consolidated billing and they do not owe the hospital for the ambulance service.

A1. If a SNF resident is taken to the hospital for outpatient services other than for those excluded from consolidated billing and they are returned to the SNF, they retain their resident status. In that case the ambulance services remains subject to consolidated billing even if the purpose of the trip is to receive a service that is itself excluded from CB.”

CMS Article SE0433 “Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services” states: “Medicare regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary’s status as a SNF resident for consolidated billing purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement on the basis that they are well beyond the typical scope of the SNF care plan. These services are the following:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnet resonance imaging (MRIs);
- Ambulatory surgery involving the use of an operating room, including the insertion, removal or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital’s gastrointestinal (GI) or endoscopy suite;
- Emergency services;
- Angiography;
- Lymphatic and Venous Procedures and;
- Radiation therapy
In these cases, any associated ambulance trips will also be considered excluded from consolidated billing. Therefore, an ambulance trip from the SNF to the hospital for one of the above listed services should be billed separately under Part B. This also holds true for return trips from the hospital to the SNF as the patient will not be considered a SNF resident until they are returned to the SNF.

Q2. If a SNF resident is transported via ambulette to a physician's office during a Medicare Part A stay for a diagnosis related to their stay, is that nursing home responsible for payment? If that is the case, would the ambulette company bill the resident directly?

A2. CMS article SE0433 “Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services” states: “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. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary—that is, that the patient’s condition is such that transportation by any other means would be medically contraindicated.” Whether you would bill the patient or the nursing home depends on arrangements your company may have with the nursing home and is not a question Medicare can answer.

Q3. If a SNF patient goes to the outpatient hospital to have Part B services such as therapy, does the facility have to provide it under consolidated billing even though the patient is not under a Part A stay?

A3. The CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 6, section 10.3 states: “Physical therapy, occupational therapy, and/or speech-language pathology services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a non-covered stay must still be billed by the SNF itself.”

Q4. Our SNF is being billed for the technical component of an MRI (listed under Major Category 1). We are being told the technical component is billable to the SNF and will not be billed by them to Part B.

A4. Physicians are required to forward the technical portions of any services to the SNF for non-excluded services that are furnished to a SNF resident in a Part A stay. The SNF will bill to the FI for payment. CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 6, section 10.1

Q5. We are providing outpatient services to a SNF patient who has have exhausted all of his SNF days. The patient is being billed by the SNF as self-pay. We are getting denials stating we should bill the SNF facility.

A5. Payment may be made under Part B for medical and other health services when furnished an inpatient of the SNF, if payment for these services cannot be made under Part A (Ex: Part A benefits are exhausted). There is a lengthy list of the types of service which may be billed by the SNF or the rendering provider under an arrangement with the SNF. To determine whether the services you are providing can be paid when a SNF resident has exhausted their benefits. The list is located in the CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 7, section 10.1.
Q6. Is hyperbaric treatment still non-covered for a SNF stay?

A6. The CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 32, section 30.1, states that HCPCS code “C1300 is not available for use other than in a hospital outpatient department. In skilled nursing facilities (SNFs) HBO therapy is part of the SNF PPS payment for beneficiaries in covered Part A stays. “

Additional reference: NCD for Hyperbaric Oxygen Therapy (CMS NCD Manual (Pub. 100-03), section 20.29)

Q7. We currently have patients that go to our hospital for dialysis, so we have to move those charges to non-covered. If we send that patient to an outpatient facility, we would not bill them for the dialysis, but would Medicare pay for the ambulance to and from the dialysis facility if it’s three days a week?

A7. Ambulance trips can be covered in this situation as long as the medical necessity criteria are met.