

CONSOLIDATED BILLING

As a result of Section 4432 of the Balanced Budget Act of 1997, SNFs are paid under a prospective payment system (PPS) for patients covered by Medicare Part A. For SNF patients in the “PPS period” (i.e., the first 100 days of a covered Part A stay), the ambulance supplier may be required to bill the SNF—not the Medicare Program—when transporting a patient for a service that is considered to be within Medicare’s PPS payment to the SNF.

When the SNF is responsible, it will generally pay the ambulance provider or supplier at the contracted rate negotiated between the parties. **Note:** It is highly recommended that you have a written agreement with SNFs specifying when they are responsible to pay and the rates that they will pay you.

For SNF in-patients, you will need to determine whether the ambulance service was provided during the PPS period (i.e., the first 100 days of a “spell of illness”), and whether the SNF or Medicare is responsible for payment for a covered service.

The PPS rules were originally based on the patient’s plan of care. CMS subsequently modified the rules so that, currently, there is a specific list of services that are excluded from Medicare’s SNF payment to the SNF, and which, therefore, can be billed directly to Medicare. All other services **must** be billed to the SNF. See CMS Manual, Pub. 100-04, Chapter 15, Section 30.2.3. The Part B Carrier should **only** be billed for:

- Transports for the initial admission to the SNF.
- Transports for the final discharge from the SNF to the home (if the patient is not returned to the SNF on the same calendar day)
- Transports for admission to the hospital.
- Discharges to the SNF following a hospital admission.
- Transports to the residence for Medicare Home Health Services.
- Transports for Dialysis.
- Transports for emergency services in a hospital.
- Transports back to the SNF following emergency services at the hospital.
- Transports to/from the hospital for MRI, CT scans, ambulatory surgery requiring an operating room, cardiac catheterization, radiation therapy, angiography, lymphatic and venous procedures.

Note: For round trips, if the first trip is exempt from PPS, the return trip is also exempt.

Services that are excluded from the PPS payment are eligible for payment under Medicare Part B. However, all other requirements for Medicare coverage must still be met, including the requirement that the patient have Part B Benefits. For patients that do not have Part B coverage, exempt services should be billed directly to the patient.

SNF CONSOLIDATED BILLING

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