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Related CR Release Date: September 2, 2005

Revised

Related CR Transmittal #: 668

Effective Date: Ambulance claims received on or after January 3, 2006 and four years after initial determination for adjustments

Implementation Date: January 3, 2006

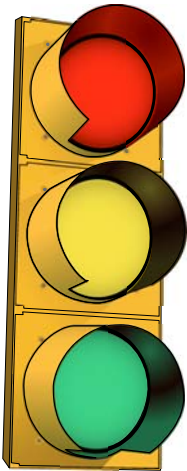
Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims During an Inpatient Stay

NOTE: This article was revised on September 6, 2005, to reflect changes made when CR3933 was revised. The only changes made to the article reflect the new CR release date and transmittal number (see above). All other information remains the same.

Provider Types Affected

Independent ambulance services suppliers billing Medicare carriers

Provider Action Needed



STOP – Impact to You

Independent ambulance services suppliers cannot bill Medicare carriers for ambulance services that they provide to hospital inpatients (on or after 12/31/04), unless the services are provided either:

- On the dates of hospital admission and/or discharge, or
- Through a prior arrangement with the hospital.

If services other than these two scenarios are billed separately as Part B, the bills will be rejected. (There are exceptions for patients of long-term care hospitals, inpatient psychiatric facilities, or inpatient rehabilitation facilities as discussed later in this article.)

CAUTION – What You Need to Know

If an ambulance supplier bills Medicare and is paid prior to Medicare's receipt of the hospital inpatient claim, Medicare will recover the improper payment from the ambulance supplier.

GO – What You Need to Do

Make sure that your billing staffs are aware of these ambulance service billing requirements.

Disclaimer

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Background

The Centers for Medicare & Medicaid Services (CMS) is strengthening its claims processing edits to detect incorrect payments to detect and prevent (or correct) improper payments to ambulance suppliers for transporting hospital inpatients. In CR 3933 (on which this article is based), CMS wants to make you aware of the rules that govern payment for the ambulance services that such suppliers provide to hospital inpatients.



Sections 1882(a)(14), 1886(d) and (g) of the Social Security Act, and Code of Federal Regulations (CFR) 411.15(m) disallow payment for ambulance services furnished to hospital inpatients on dates that fall between the patients' admission and discharge dates, unless the hospital bills for services directly or makes special arrangements for the services with the independent ambulance supplier.

As a result, the independent supplier of ambulance services must look to the hospital for payment for these services, rather than to the Medicare beneficiary or carrier. More specifically, with the exception of services on the admission and discharge dates, all ambulance transportation provided to hospital inpatients must be bundled into the hospital bill. Medicare carriers will reject any bill for ambulance services that are provided to a hospital inpatient on a date that falls between their admission and discharge dates.

In summary, here is how this process works. Effective for dates of service on or after December 31, 2004, Medicare's systems search the paid claim histories of independent suppliers of ambulance services and compares the line item service dates (line items with specialty codes of "59") on the ambulance claims to the admission and discharge dates on hospital inpatient stays. Medicare then rejects the line items when an ambulance line item service date falls between the admission and discharge dates on a hospital inpatient bill.

And, if Medicare receives the ambulance claim prior to receiving the hospital inpatient bill, it performs the same search and if the ambulance claim falls within the admission and discharge dates, the ambulance claim is adjusted and the incorrect payment for the ambulance service will be recovered from the ambulance supplier.

Note: There is a special group of ambulance transportation payment situations that are permitted for inpatients of certain facilities. Specifically, these payments are permitted when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF), or inpatient rehabilitation facility (IRF), and is transported by ambulance to an acute care hospital to receive specialized services and the service date falls within the occurrence span code 74 (non-covered level of care) from and through dates, plus one day, on a LTCH, IPF, or IRF bill.

Finally, when Medicare rejects/adjusts an ambulance claim, the carrier will indicate, by using Remittance Advice Remark Code M2: "Not paid separately when the patient is an inpatient;" that:

1. The ambulance transportation occurred during a hospital inpatient stay (on a date that falls within the admission and discharge dates of a covered hospital inpatient stay), and is not separately payable, or
2. The service date falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF, and is not separately payable.

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In addition, the carrier will also indicate the adjustment using Remittance Advice (RA) Adjustment Reason Code 97 "Payment is included in the allowance for another service/procedure."

Additional Information

You can find more information about the payment of ambulance claims during an inpatient stay by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3933 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the *Medicare Claims Processing Manual, Chapter 3 (Inpatient Part A Hospital) Section 10.5 (Hospital Inpatient Bundling)*. You can find this manual chapter as an attachment to CR3933.

Finally, if you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS web site.

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