

New Nursing Home Rule Requires Written Agreements for Ambulance Services and Payments

By: G. Christopher Kelly

Certain ambulance trips must be paid by nursing homes instead of Medicare Part B. Effective October 4, 2004, agreements between nursing homes and ambulance services regarding these trips must be in writing. As part of the Balanced Budget Act, Skilled Nursing Facilities (“SNFs”) began in 1999 to get payments under a prospective payment system (“PPS”). Under the PPS, the facility is paid a set per diem amount for every patient that the SNF has during a “Medicare Covered Stay”. A Medicare Covered Stay is defined as a SNF stay of up to 100 days after a Part A hospital stay.

During this “Medicare Covered Stay”, certain services are considered covered by the per diem payment, including transportation of a patient to or from a site **other than** a physician’s office or hospital. For example, a trip to an independent diagnostic testing facility, a cancer treatment center, radiation therapy, or a wound care center would be paid to the ambulance service by the SNF, and should not be billed by the ambulance service to the Part B carrier. Also, a transfer of a patient from one SNF to another before midnight of the same day is also included in the per diem payment. For transports to a physician’s office or hospital, the ambulance service should still be billed to Part B.

In a Medicare Transmittal, CMS said that for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as an ambulance service) under an “arrangement”. This “arrangement” must now constitute a written agreement to reimburse the outside entity for Medicare-covered services subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF (like the examples above). NOTE: Transportation to and from dialysis services has been specifically excluded from the per diem payment and should still be billed to the Part B carriers for those patients who qualify for transportation.

CMS noted the problems with requiring service providers, such as ambulance services, to ascertain whether the patient is in a “Medicare Covered Stay”. In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare-covered and included in the SNF’s global PPS per diem. CMS also noted that whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only in Medicare’s non-coverage of the services themselves, but also in the imposition of civil money penalties according to CMS.

CMS stated that in order to help prevent these types of problems from arising, a written agreement is required between the SNF and the service provider. Medicare's per diem payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to Part B) for its payment. Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier, which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist, the SNF *must have* a written agreement in place with its supplier, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF.

This rule actually affects a rather small number of ambulance transports. An example of when this rule applies is: A patient has a Part A hospital stay for a broken hip resulting from a fall. Upon their admission or return to a SNF, the patient has a "Medicare Covered SNF Stay" for up to 100 days. During that time, transports other than to a physician's office or hospital, are considered paid by Medicare to the SNF as part of the per diem for the Medicare Covered Stay. The SNF then has the responsibility to provide those service *or* contract in writing with another entity to provide the services for them. If the SNF chooses to contract with an outside entity, for example an ambulance service for transportation needs, then since the SNF has already been paid by Medicare for the service, it is the SNF's responsibility to pay the ambulance service.

The moral of the story is that ambulance services that transport SNF patients need to develop a written agreement with the SNF regarding patients in a Medicare Covered Stay. The written agreement should make sure that it is the responsibility of the SNF to let the ambulance service know which patients are in a Medicare Covered Stay and to pay the ambulance service accordingly.

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