

Understanding SNF Consolidated Billing: Transporting Part A Residents

by Amanda Wetzel

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Abbreviations Key

ABN = Advanced Beneficiary Notice of Non-Coverage

PA = Prior Authorization

CB = Consolidated Billing

RSNAT = Repetitive, Scheduled Non-Emergent Ambulance Transport

CMS = Centers for Medicare & Medicaid Services

RT = Round Trip

CWF = Common Working File

SNF = Skilled Nursing Facility

EMT = Emergency Medical Technician

ER = Emergency Room

ESRD = End Stage Renal Disease

ET = Emergency Treatment

HCPCS = Healthcare Common procedure Coding System

MAC = Medicare Administrative Contractor



Helpful terms to understand:

Bundled = SNF is responsible for payment under CB. SNF pays the provider per terms of arrangement, typically Medicare Fee Schedule Rate based on site of service. *See CMS Best Practice Guidelines (slide 44)

Excluded = The SNF is not responsible for payment of a Medicare-covered service under CB. Provider bills Medicare Part B for payment consideration.

Non-Covered = Neither Medicare or the SNF will consider for payment under CB. Responsible party and payment terms are determined by contract/provider arrangement.

Medically Necessary = Item, service, action, treatment that is required to maintain or improve patient's health.



What is Consolidated Billing? When does this system start, pause or end?



What is Consolidated Billing (CB)?

All billed claims or invoices the SNF receives with a patient name should be assessed for Consolidated Billing (including but not limited to):

- Lab Services
- Hospital Claims
- Physician Office Visits
- Specialty Care
- Ambulance Transport
- Drugs
- Psychiatric Care
- Durable Medical Equipment



What is Consolidated Billing (CB)?

The term “Consolidated Billing” refers to Medicare’s specific set of billing guidelines which apply only to nursing home resident bills that are covered under their Medicare Part A benefit.

(Part A = the first 100 days an ORIGINAL Medicare beneficiary resides in a SNF)

*contracts may mirror CB policy for other payor types – this is not true Consolidated Billing and all CB guidelines set by CMS may not apply.

Part A stay must be ACTIVE, meaning there are no interruptions, suspensions or temporary CB pauses taking place for the billed date of service.



When is CB status suspended?

Reasons for temporary pauses of CB:

- Qualifying Emergency Event – Patient sent to the nearest hospital ER by ambulance to receive immediate, emergency services
- Absence from SNF spans midnight and there is no formal discharge (SNF absence does not exceed 3 midnights)
- Major Category 1 Excluded Procedure/Service done Outpatient at Hospital

*In all above scenarios, CB suspends when resident exits the SNF and does not reinstate until resident has physically returned. ANYTHING provided during a suspension is NOT bundled to the SNF. This includes related RT medically necessary ambulance transports.



EMERGENCY



When does CB interruption due to an Emergency start/end?

- Emergency Event **Starts: When the EMT intervenes to provide emergency level of care.** The EMT is now deciding what care is necessary to safely transport patient to the ER where additional evaluation/care is provided.
- EMT's are licensed within your state to evaluate and provide emergency level of care and operate all lifesaving machinery and issue medical supplies that are aboard the ambulance.
- Anything provided during an ER visit AND care provided in other areas of the hospital immediately following the ER visit are all excluded from Consolidated Billing.
- Emergency INTERRUPTION **Resolves: After the patient is returned to the SNF.** SNF staff are once again making care decisions with/for the resident.



What transport qualifies as an emergency?

1) Patient sent to the nearest* ER.

*Nearest can also mean FASTEST destination when accounting for traffic. EMT must select the ER that is FASTEST to travel to when SNFs have multiple ER's in equal distance or there is some kind of obstacle that will cause it to take longer to get to the ER that is geographically closer.

AND

2) The patient receives immediate, emergency services in the hospital emergency room.

*The hospital being the destination does not automatically mean an emergency is taking place. Patients can also enter the ER without a true emergency present. Not every trip to the hospital is to the ER.

AND

3) Travel to ER destination is done by medically necessary ambulance.

*Medically Necessary Ambulance Transport = it would be unsafe for a patient to travel by any other means. Patient requires supervision/care of EMT and/or the use of machinery and/or supplies aboard the ambulance.



How to identify Ambulance Transport

A true ambulance is equipped with lights/sirens, life saving machinery, medical supplies and is operated by a team of Emergency Medical Technicians (EMTs).

Ambulance



Non Ambulance



Wheelchair-Van, Stretcher-Limo, "Cabulance", "Ambulette" and ANY other transport services can never count as ambulance transport. Non-ambulance transports are NOT a Medicare covered service.



Emergency claim common billing issues that can cause incorrect ambulance denials.

- Hospital Billing is incorrect: Initial hospital ER claim must have REV code 0450 listed for initial ER visit AND ET modifier added to all related charges on subsequent dates of service. This is how CWF is programmed to bypass CB edits and allow the claim to pay the hospital AND corresponding ambulance claim.

Possible reasons for missing 0450 REV code: (including but not limited to)

- a) Patient is sent to ER, assessed and then not admitted to ER and sent back to the SNF
- b) Patient is sent to the hospital, but not seen in the ER and are sent directly to imaging or another area in the hospital that is not part of the ER
- c) Hospital biller makes an error and uses an alternate REV code.

Possible reasons for missing ET modifier: (including but not limited to)

- a) The hospital biller is unaware of this Consolidated Billing-specific modifier
- b) The ET modifier is left off in error



Emergency claim common billing issues that can cause incorrect ambulance denials.

- Billing is not done in correct sequence: Ambulance providers must wait for the hospital to file the ER claim before submitting a corresponding ER transport claim. If there is no hospital ER claim for CWF to match the ambulance claim to, the claim will incorrectly deny stating SNF is responsible since there is no documented emergency yet.

*The hospital ER claim itself is what causes CWF to pause Consolidated Billing edits and allow the ambulance claim to process correctly.



Emergency claim common billing issues that can cause incorrect ambulance denials.

- Hospital orders ambulance for patients lacking medical necessity to return them to the SNF.
*Just because a patient requires an ambulance to ARRIVE to the ER does not automatically mean the patient also requires an ambulance to return to the SNF when exiting the ER.

*Medically Necessary Ambulance Transport = it would be unsafe for a patient to travel by any other means. Patient requires supervision/care of EMT and/or the use of machinery and/or supplies aboard the ambulance.

CMS Medicare Claims Processing Manual, Chapter 6:

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf>

- Section 20.1.2.2 - Emergency Services (page 22)
- Section 10.1 - Consolidated Billing Requirement for SNFs (page 7)



OVERNIGHT SNF ABSENCE



When does the CB interruption due to an overnight SNF Absence start/end?

When a Part A resident is absent from the SNF overnight, this triggers a suspension in Consolidated Billing.

- Suspension starts when the resident exits the SNF *(not at midnight)
- The suspension does not resolve until AFTER the resident is returned to the SNF
- ALL charges for ANY care provided during a suspension are excluded from Consolidated Billing
- Even when patients are held for observation at a hospital setting (non-admitted status), ALL care provided is billed by the hospital directly to Medicare.
- Charges accrued on the same billing date as the patient's return to the SNF are still taking place during the suspension and are correctly billed directly to Medicare by the provider. Even ambulance!



When does the CB interruption due to an overnight SNF Absence start/end?

The “Midnight Rule” :

The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before the following midnight. This provision is sometimes referred to as the “midnight rule” (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §20.1, which specifies that an inpatient day “. . . begins at midnight and ends 24 hours later”). A “discharge” from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

Overnight Absence Policy :

When a beneficiary is absent from the SNF overnight (i.e., the absence from the SNF spans midnight), the beneficiary’s status as a SNF “resident” for CB purposes would end upon the point of departure from the SNF (per the above-described “midnight rule”), and would not resume until the actual point of arrival back at the SNF the next day. Accordingly, that beneficiary would not be considered a SNF “resident” for CB purposes between those two points, so that any offsite services furnished during the interim (such as an overnight sleep study) would not be subject to CB.

Billing guidance and examples: CMS Medicare Claims Processing Manual, Chapter 6:

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf>

- Section 10.1 – Consolidated Billing Requirement for SNFs (page 6)
- Section 120.2 – Interrupted Stay Policy (page 89)
- Section 40.3.2 – Patient Readmitted Within 30 Days After Discharge (page 48)
- Section 40.3.5.2 - Leave of Absence (page 51)
- Section 110.2.2 - A/B Crossover Edits (page 82)



Overnight SNF absence common billing issues that can cause incorrect ambulance denials.

- Billing is not done in correct sequence: Providers must wait for SNF to file code 74 for Interrupted Stay on SNF claim to Part A before submitting provider claims to Part B.

Occurrence span code 74 is what triggers CWF to bypass CB edits and allow payment to providers.

*Most providers bill Part B weekly while the SNF can only bill Part A monthly.

Examples:

- a) Hospital outpatient charges on return to SNF date.
- b) Return to SNF ambulance transport following an overnight absence
- c) Overnight Sleep Study charges on return to SNF date

*If SNF goes back and makes a correction to their claim, adding the 74 later, they must let providers know a change was made so they can submit their claim after. Many provider agreements will put the SNF at fault if your claim error blocks the provider from being able to submit their claim timely.



Why do patients return to the SNF in an ambulance when Medical Necessity is not met?

Ambulance ordered for patients lacking medical necessity to return them to the SNF.

*Medically Necessary Ambulance Transport = it would be unsafe for a patient to travel by any other means.

The patient requires the supervision/care of an EMT and/or the use of machinery and/or supplies aboard the ambulance.

Examples:

- a) Patient is being discharged from hospital and needs a wheelchair or stretcher transport but wheelchair or stretcher van is not available.
- b) Patient is being discharged and demands an ambulance when medical necessity is not met.
- c) Hospital does not want to wait for appropriate transport and orders the ambulance for convenience.
- d) SNF requests an ambulance transport in order to get the patient back more quickly.**

**in this case, the SNF would be accepting payment responsibility outside of Consolidated Billing.



MAJOR CATEGORY 1 EXCLUDED SERVICES



Major Category 1.A-F: Hospital Outpatient Exclusions

These are certain services that can cause an entire claim and corresponding ambulance claims to be become excluded!

*more on these in the exclusion section of the presentation

Major Category 1 - Exclusion of Services Beyond the Scope of a SNF

These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH) only, **not by a SNF**, and are excluded from SNF PPS and CII for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CII, with exceptions as listed below.

- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 00011 - 00211, 00241 - 00261, or 10021 - 49990 (except HCPCS codes listed as inclusions under Major Category 1F) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

NOTE: Services billed by providers to the Medicare Administrative Contractor represent the facility charge portion for those services.

Major Category 1 is further broken down into subcategories:

- A. Computerized Axial Tomography (CT) Scans
- B. Cardiac Catheterization
- C. Magnetic Resonance Imaging (MRIs)
- D. Radiation Therapy
- E. Angiography, Lymphatic, Venous and Related Procedures
- F. Outpatient Surgery and Related Procedures—**INCLUSION** (see note below)

Note: Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing **minor procedures that can be performed in the SNF itself**. The physician's service itself may be excluded for the codes listed (identified in the Carrier A/B MAC files) in this section, however, when these codes are billed by the hospital they are for the technical/facility charge and are not excluded.



Can I screen claims for Interruptions in CB?

- **Qualifying Emergency Event**
 - This will be a claim/bill sent from a hospital or ambulance provider
 - Scan bills for the word "Emergency"
 - Check patient's chart for trips to the ER
 - UB04 Claim forms will show a REV code of 0450 for Emergency Room
- **SNF Absence Spans Midnight**
 - Check for consecutive dates of service billed on one claim/occurrence
 - *Statement/Roster-style bills will be more difficult to identify – you may need to verify overnight absence in the patient's chart.
 - ** "Hospital Stay Less Than 24 Hours" can still mean interruption spanned midnight
- **Excluded Services that cause an Interruption in Consolidated Billing**
 - This can usually not be determined at first glance; you will need to research every code billed for the occurrence and see if any item(s) is/are excluded in the specific scenario provided.
 - "Major Category 1 Excluded Services" are only excluded when provided in a hospital setting and cause normally "bundled" codes to become excluded – any other services billed on the same LIDOS (Line Item Date Of Service) also become excluded

*Note – Drugs and services excluded by STATUTE are excluded regardless of setting and are not considered an "Interruption" in CB



How does the Consolidated Billing system work?



Which patients qualify for the Part A Stay?

To become Part A, the patient must meet the following requirements:

- 1) Be enrolled in original Medicare during 3 day qualifying hospital stay
 - The parameters of what Medicare covers does not change in a SNF setting
 - Any time Consolidated Billing is not in play, the patient reverts back to original Medicare
 - Level of care is established during 3 day stay = rate SNF receives from Medicare to cover care
- 2) Be enrolled at a Medicare-certified SNF within 30 days of hospital discharge (when appropriate within 30 days)
- 3) Require skilled-level of daily nursing or rehab services at admission and ongoing
 - A change in patient medical needs can cause a change in daily rate amount
 - Residents no longer requiring skilled daily nursing or rehab services will discharge Part A Stay



*Part A benefit exhausts at 100 days, but patients can discharge Part A any time

How Does The CB System Work?

Medicare-Certified SNFs receive a daily payment of Medicare funds for each in-house Part A resident, during their covered 100 days. The SNF is then responsible for providing all Medicare covered services.

When the SNF cannot provide the patient with needed care, they enlist the help of other providers. These providers then look to the SNF for payment.

*Unless care has been excluded from the SNF bundle, the SNF is responsible for payment. But how much should the SNF pay?



How much does the SNF pay for services?

The SNF is **REQUIRED** to have a formal arrangement on file with any entity that provides care/services to the SNF's residents. (more on this later)

Although there is no statute set by CMS for what amount the SNF must pay a provider, the industry standard is for the SNF to pay providers the same as when providers are paid by Medicare Part B – aka "The Medicare Rate"



How much does the SNF pay for services?

Medicare reimburses Ambulance providers based off of the CMS
Ambulance Fee schedule.

These payment rates vary by locality and date of service and are managed by the MAC processing the claim. CMS lists informational Fee schedule resources for ambulance, here:

<https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files>



Where can I look up ambulance rates?

Ambulance Fee Schedule Public Use Files

These AFS Public Use Files (PUFs) are for informational purposes only. All official fee schedule files that are used to process Medicare claims are maintained by the Medicare Administrative Contractors (MACs) and could vary slightly from the amounts referenced in these files.

Expand a menu to view information about the Ambulance Fee Schedule PUFs:

> CY 2004 - CY 2026

▼ CY 2026

The Consolidated Appropriations Act, 2026, includes a provision pertaining to the extension of the temporary ground ambulance transport add-on payments that were set to expire on January 31, 2026.

> Temporary Ground Ambulance Transport Add-on Payments

> Data Elements of the AFS Data File

Downloads

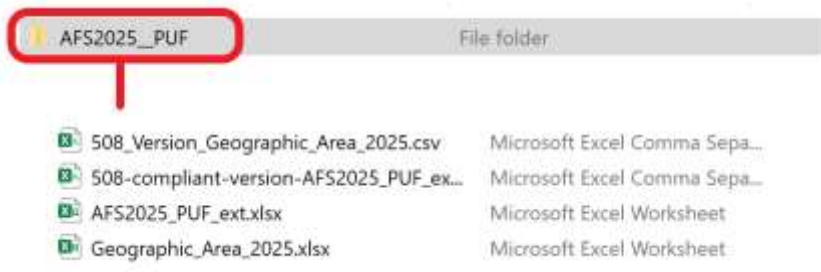
[CY 2026 File \(ZIP\)](#)

[CY 2025 File \(ZIP\)](#)

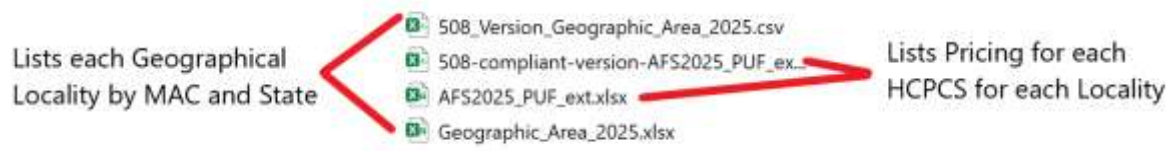


Where can I look up ambulance rates?

Once you open the Zip file, there will be 4 downloadable files.



Where can I look up ambulance rates?



Where can I look up ambulance rates?

The explanation for how rates are calculated are explained in the “Data Elements Of the AFS Data File” on the CMS website:

<https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files>

Ambulance Fee Schedule Public Use Files

These AFS Public Use Files (PUFs) are for informational purposes only. All official fee schedule files that are used to process Medicare claims are maintained by the Medicare Administrative Contractors (MACs) and could vary slightly from the amounts referenced in these files.

Expand a menu to view information about the Ambulance Fee Schedule PUFs:

- > CY 2004 - CY 2025
- > CY 2025
- > Temporary Ground Ambulance Transport Add-on Payments:
- > **Data Elements of the AFS Data File**



Where do I find Ambulance Rates?

Locate your MAC code (15202 = Ohio) and Locality (00 for all of Ohio) and then reference the applicable column:

CONTRACTOR/ CARRIER	LOCALITY	HCPC	RVL	GPC	BASE RATE	URBAN BASE RATE / URBAN MILEAGE	RURAL BASE RATE / RURAL MILEAGE	RURAL BASE RATE / LOWEST QUARTILE	RURAL GROUND MILES 1-17*
15202	00	A0425	1.00	0.913	\$9.15	\$9.33	\$9.42	n/a	\$14.13
15202	00	A0426	1.20	0.913	\$284.56	\$327.09	\$330.30	\$404.95	n/a
15202	00	A0427	1.90	0.913	\$284.56	\$517.89	\$522.97	\$641.16	n/a
15202	00	A0428	1.00	0.913	\$284.56	\$272.57	\$275.25	\$337.46	n/a
15202	00	A0429	1.60	0.913	\$284.56	\$436.12	\$440.39	\$539.92	n/a
15202	00	A0430	1.00	0.913	\$3,861.62	\$3,693.64	\$5,540.46	n/a	\$5,540.46
15202	00	A0431	1.00	0.913	\$4,489.71	\$4,294.41	\$6,441.62	n/a	\$6,441.62
15202	00	A0432	1.75	0.913	\$284.56	\$477.01	\$481.68	n/a	n/a
15202	00	A0433	2.75	0.913	\$284.56	\$749.58	\$756.93	\$928.00	n/a
15202	00	A0434	3.25	0.913	\$284.56	\$885.87	\$894.55	\$1,096.72	n/a
15202	00	A0435	1.00	0.913	\$10.98	\$10.98	\$16.44	n/a	\$16.44
15202	00	A0436	1.00	0.913	\$29.23	\$29.23	\$43.85	n/a	\$43.85

A0428: Urban= \$272.57 and Rural \$275.25 (**approx. -remember MACs may adjust)



What is excluded from Consolidated Billing?



What Is An Excluded Service?

*Non-Medicare-Covered Services are not the same as Medicare **COVERED** Consolidated Billing Excluded Services

Not covered by Medicare or the SNF

The SNF is not responsible to pay, providers can bill Medicare Part B, directly.

Codes excluded by statute

The 5 Major Categories of Excluded Services:

(always excluded in any setting) example:

(excluded by specific scenario) example:

2025 Part B MAC Update:

2025 Part A MAC Update:

<https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing/2025-part-b-mac-update>

<https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing/2025-part-mac-update>

- Professional Services
- Global Services
- Specifically Excluded

- Beyond the Scope Of SNF Services (Hosp Outpatient)
- Chemotherapy Exclusions
- Dialysis



*above examples are "including but not limited to"

Which Ambulance Services are not covered vs excluded?

All transport by Ambulance must be medically necessary in order to be “Medicare-covered”

- If the patient does not meet medical necessity for the ambulance, the trip is NOT COVERED by Medicare OR the SNF. ABN (Form CMS-R-131) must be issued and ambulance provider bills the resident.

Common occurrences – return to SNF after ER visit. (ABN cannot be used during a true emergency)

*Complete ABN instructions on CMS website : <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN>

*If hospital orders ambulance but medical necessity is not met, this does not make the SNF responsible.

- If the patient meets medical necessity for an ambulance and is transported to the hospital for a non-emergent, non-excluded reason, the transport is bundled to the SNF and no interruption in Consolidated Billing takes place, unless SNF absence spans midnight.

*medically necessary ambulance transport to scheduled appointments are NOT excluded unless:

- Transport is to/from dialysis
- Transport is to/from hospital outpatient for Category 1 excluded service
- Transport takes place pre-admission – including during an interruption/suspension of CB.



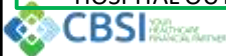
Which excluded services cause the ambulance ride to also exclude?



5 Major Categories Explained: Category 1.A-E: Hospital Outpatient Exclusions

Major Category 1 Excluded Services

- Must be provided in a hospital outpatient setting
- All directly related services become exclusions in this scenario (even ambulance)
- Patient must meet medical necessity for hospital setting (medical reason why they require hospital)
- Patient must meet medical necessity for ambulance
- Patient’s need for procedure itself must be considered reasonable and necessary.
- **ALL MEDICALLY NECESSARY TRANSPORT TO/FROM A MAJOR CATEGORY 1 EXCLUDED SERVICE IN THE HOSPITAL OUTPATIENT IS ALSO EXCLUDED!!**



Major Category 1 - Exclusion of Services Beyond the Scope of a SNF

These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH) only, **not by a SNF**, and are excluded from SNF PPS and CIL for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery ICDPCS codes 09011 – 09211, 09241 – 09261, or 10021 – 09990 (except ICDPCS codes listed as inclusions under Major Category 1.F) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

NOTE: Services billed by providers to the Medicare Administrative Contractor represent the facility charge portion for those services.

Major Category 1 is further broken down into subcategories:

- A. Computerized Axial Tomography (CT) Scans
- B. Cardiac Catheterization
- C. Magnetic Resonance Imaging (MRIs)
- D. Radiation Therapy
- E. Angiography, Lymphatic, Venous and Related Procedures
- F. Outpatient Surgery and Related Procedures- **INCLUSION** (see note below)

Note: Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate odds around the much shorter list of inclusions under this category, representing **minor procedures that can be performed in the SNF itself**. The physician’s service itself may be excluded for the codes listed (identified in the Carrier A/B MAC files) in this section, however, when these codes are billed by the hospital they are for the technical/facility charge and are not excluded.

5 Major Categories Explained: Category 1.F: Hospital Outpatient INCLUSIONS

Listing surgical procedures done in the hospital setting that are bundled to the SNF is much shorter than those which are excluded, therefore, instead of an “exclusion” list, for Cat 1.F scenario, we have “inclusions”

To Be Excluded (hospital bills Medicare):

- Procedure must be “surgical” in nature
- Hospital setting is required
- Procedure cannot be done safely at SNF

Example of an Exclusion:

- Surgical placement of a pacemaker; could never safely be done in a SNF

*Ambulance is also excluded

Inclusions (hospital bills SNF – Major Category 1.F):

- Procedure is considered “minor” or non-surgical
- Can be performed at the SNF in other scenarios and hospital setting is only required for specific safety issue

Example of an Inclusion:

Extraction of an infected toenail; resident is diabetic and hospital setting is required for safety. Non-diabetic residents can have same procedure safely in other settings.

*Ambulance is **NOT** excluded – bundled to the SNF



5 Major Categories Explained: Category 1.G-H: Emergency Services (Hospital and Ambulance)

An “Emergency” for Consolidated Billing Purposes is defined by Medicare as: when an immediate, necessary trip by ambulance, to the nearest Emergency Room, where emergency services are administered to the patient, takes place.

*Patients entering the hospital through the Emergency Department for convenience does not count as a true Medically Necessary Emergency Situation to validate an ambulance transport – even though evaluation and care provided in ER is still excluded from CB.

G. Emergency Services

These services are identified on claims submitted to Part A MACs by a hospital or CAH using revenue code 045x (Emergency Room—“x” represents a varying third digit). Related services with the same line item date of service (LIDOS) are also excluded. Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.

Note: In order to bypass services related to the ER encounter, which are performed on subsequent service dates, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. Please review Change Request 5389 for further information.

H. Ambulance Trips – With Application to Major Category II

Note: Ambulance trips associated with Major Category I.A-E and G services are excluded from SNF CB. In addition, ambulance trips associated with Major Category II. A. services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.



5 Major Categories Explained: Category 2.A: Dialysis and ESRD Services

“Other Dialysis Related Services”

*Medically necessary AMBULANCE transport to/from dialysis is also excluded from Consolidated Billing.

Major Category II - Additional Services Excluded when Rendered to Specific Beneficiaries

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. Services (dialysis, etc.) when the SNF is the place of service, as to receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

NOTE: This category also excludes non-ESRD acute dialysis from SNF CB, as set forth in §20.2.1 of the Medicare Claims Processing Manual, Chapter 6.

A. Dialysis, EPO, Aranesp, and Other Dialysis Related Services for ESRD Beneficiaries

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases: (1) when the services are provided in a RDF (including ambulance services listed under Major Category 1. above), (2) home dialysis when the SNF constitutes the home of the beneficiary, and (3) when the drugs EPO or Aranesp are used for ESRD beneficiaries. Note that SNFs may not be paid for home dialysis supplies.

*Be aware of the Prior Authorization (PA) Requirement for ambulance providers to obtain on reoccurring ambulance transport (slide 30)



When does transport need a PA?

Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)

- Prior authorization for RSNAT is voluntary. However, if an ambulance supplier elects to bypass prior authorization, applicable RSNAT claims will be subject to a prepayment medical review. Claims for the first three round trips are permitted to be billed without prior authorization and without being subject to prepayment medical review.
- RSNAT = A repetitive, non-emergent ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a ten-day period; or at least once per week for at least three consecutive weeks.
- Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment. In the case of Dialysis, these ambulance transports (when medically necessary) are excluded from Consolidated Billing.
- Ambulance providers experiencing a delay in payment may confuse this as a denial and try to bill the SNF.
- Start dates for this program were introduced as early as 2014 in some states, but is practiced in all states as of the close of 2022. For complete program details and guidelines, please see the RSNAT info page on CMS.gov, here:
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuth_OperationalGuide_123115.pdf



5 Major Categories Explained: Category 3.A-B: Chemotherapy and Chemo Admin

CHEMOTHERAPY REMINDER

Medicare-covered Chemotherapy drugs that are in pill-form fall under the prescription drug portion of Consolidated Billing and will be bundled to the SNF, unless excluded for another reason. Oral drugs in pill-form do not meet Major Category III Exclusion Requirements.

*Prescription drugs in pill-form are bundled to the SNF if covered by Medicare unless specifically excluded for another reason.

Major Category III - Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

- A. Chemotherapy
- B. Chemotherapy Administration

Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services and physician orders must exist to support the provision of chemotherapy. Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

- C. Radioisotopes and their Administration
- D. Customized Prosthetic Devices
- E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.



5 Major Categories Explained: Category 3.A-B: Chemotherapy and Chemo Admin

Chemotherapy Liquid Treatments – provided by shot, injection, IV push or continuous IV CAN meet the criteria for exclusion, as can some associated administration costs.

- If the drug itself is excluded, then site of service is not considered
- If the drug is not fighting a diagnosis of cancer, then it does not meet the criteria for exclusion, even if it is part of the Chemotherapy plan of care.

Example:

Iron infusions treating anemia caused by Chemotherapy are not excluded in this case – anemia is a secondary diagnosis and not excluded since it is not helping to fight the actual cancer.

*Medically necessary ambulance trips to receive Chemo treatments are NOT excluded from Consolidated Billing. These trips would be bundled to the SNF, unless the patient is out overnight.



5 Major Categories Explained: Category 3.C-E: Radioisotopes and Admin, Custom Prosthetics and Hemophilia

C. Radioisotopes and their Administration

D. Customized Prosthetic Devices

E. Hemophilia Exclusions

*Reminder - exclusions must be identified by HCPCS

*Medically necessary ambulance trips to appointments are NOT excluded from Consolidated Billing. These trips would be bundled to the SNF, unless the patient is out overnight.

Major Category III - Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

- A. Chemotherapy
- B. Chemotherapy Administration

Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services and physician orders must exist to support the provision of chemotherapy. Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

- C. Radioisotopes and their Administration
- D. Customized Prosthetic Devices
- E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.



5 Major Categories Explained: Category 4.A-K: Preventative and Screening Services

Billing Reminder

Exclusion is by way of reimbursement.

If residents receive Screening and Preventative Services from an off-site provider, the SNF must pay that provider for services and then bill Part B for reimbursement.

Non-SNF providers will be denied if they try to bill Part B, directly.

Major Category IV - Additional Excluded Preventive and Screening Services

These services are covered as Part B benefits and are not included in SNF PPS. Such services must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22X. Swing Bed providers must use TOB 12X for eligible beneficiaries in a Part A SNF level.

Note: Please access Chapter 18 "Preventive and Screening Services" of the Claims Processing manual for coverage and billing guidance.

- A. Mammography
- B. Vaccines (Pneumococcal, Flu, Hepatitis B, or Covid-19)
- C. Vaccine Administration
- D. Screening Pap Smear and Pelvic Exams
- E. Colorectal Screening Services
- F. Prostate Cancer Screening
- G. Glaucoma Screening
- H. Diabetic Screening
- I. Cardiovascular Screening
- J. Initial Preventative Physical Exam
- K. Abdominal Aortic Aneurysms (AAA) Screening

*Medically necessary ambulance trips to appointments are NOT excluded from Consolidated Billing. These trips would be bundled to the SNF, unless the patient is out overnight.



5 Major Categories Explained: Category 5.A: Therapy INCLUSION

Billing Reminder

If residents receive Therapy Services from an off-site provider, the SNF must pay that provider for services and the ambulance ride for the appointment.

MOST therapy services cannot be billed to Part B by the SNF for reimbursement.

Non-SNF providers will be denied if they try to bill Part B, directly.

Therapies listed as Cat V on the annual file are INCLUDED, meaning they are bundled to the SNF for payment:

<https://www.cms.gov/files/zip/2025-annual-snf-consolidated-billing-hcpcs-update.zip>

Major Category V - Part B Services Included in SNF Consolidated Billing

Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents.

- A. Therapies billed with revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)



Which providers participate in Consolidated Billing?



Do All Providers Participate in CB?

When a physician or supplier is Medicare Certified, it is generally understood and expected that they will accept the terms of Medicare's Consolidated Billing Fee Schedules, however, it is NOT required.

Medicare-Certified providers can demand up to Medicare's "Limiting Charge" when billing beneficiaries only!

Medicare states SNFs are REQUIRED to enter into a formal arrangement BEFORE any bundled services are rendered to a Part A resident by anyone other than the SNF itself, to ensure all parties are agreeable to the terms of the program, in advance.



Skilled Nursing Facility (SNF)

Private Inmate Payment Model

Wage Index

Consolidated Billing

Billing and Pre-billing

SNF 2025 Revenue Model

SNF Revenue-Charter and Reports

Education & Training

List of SNF Federal Regulations

Best Practices Guidelines

Arrangement Required

On May 31, 2024, we issued an instruction (Change Request CR1-2024, Transmittal 163) regarding the longstanding requirement for a skilled nursing facility (SNF) to enter into an arrangement with any outside supplier from which the SNF's residents receive "bundled" services (i.e., services that are subject to SNF consolidated billing).

Comments were expressed that an SNF needs to execute a formalized contract, drafted in accordance to State law, with every outside entity that furnishes such services to its residents. In fact, while executing such a formalized contract with a supplier would indeed be one way to satisfy the requirement for an "arrangement," this is not the only acceptable way. On December 23, 2024, we issued another instruction (CR 2020, Transmittal 470), which provides further clarifications concerning the nature of the arrangement between an SNF and its supplier. As explained in greater detail below, the SNF can effect an "arrangement" through any means that specifies --

the arrangement for services for which the SNF assumes responsibility, and

the manner in which the SNF will pay the supplier for those services.

While entering into a formalized legal contract may well be a routine business practice with regard to those suppliers with which an SNF has a routine, ongoing relationship, this may be less feasible in connection with other entities that serve the SNF's residents on only an occasional or irregular basis. For example, an SNF may occasionally refer one of its Part A residents to an off-site clinic to receive certain bundled procedures, such as diagnostic tests. Rather than executing a formalized contract with the clinic in advance, the SNF may instead prepare a document that accompanies the resident. For example, the document could verify the clinic of the following:

That Medicare Part A is covering the resident's SNF stay, so that the clinic must bill the SNF (rather than Part B) for any bundled services that it furnishes to the resident;

The particular bundled services that the beneficiary is being sent to receive and the terms of the SNF's payment to the clinic for those services;

That before furnishing any bundled services beyond those specified in referring the beneficiary to any other entity to receive such services the clinic must first contact the SNF; and

That by furnishing services to the beneficiary, the clinic agrees to the terms set forth in the agreement by the SNF.

We also wish to clarify that the absence of an agreement—written or verbal—does not relieve the SNF of its overall responsibility to furnish directly or make arrangements for all services that are subject to the consolidated billing requirement. When an SNF refuses to reimburse a supplier for furnishing such a service to the SNF's resident, it is the SNF's failure to enter into a valid arrangement for the service (rather than the absence of written documentation) that is inconsistent with the terms of the SNF's Medicare provider agreement under Section 1000(a)(1)(H)(ii) of the Social Security Act.

Billing Reminder

How does the SNF identify "bundled" services?

The ONLY way to identify which codes are "bundled" or "excluded" is to check CMS files for HCPCS that are listed as an exclusion (or inclusion).

The SNF must alert providers that the ONLY way to meet this REQUIREMENT is to obtain an advance plan of care listing all HCPCS expected to be billed and screen for bundled services.

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Ambulance provider arrangements:

Most Ambulance providers will ONLY offer the Medicare rate to SNFs which whom they have contracted with...

Since there are usually a limited number of ambulance providers in any given area, they are sometimes harder to get in place.

Ambulance providers will typically contract with SNFs where:

- 1) The SNF gives exclusive preference to their specific company.
- 2) The SNF agrees to pay within a certain timeframe.
- 3) The SNF agrees to pay when Medicare Denies***



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Ambulance provider arrangements:

The SNF agrees to pay when Medicare Denies***

Medicare denials can occur for many reasons, including but not limited to:

- Timely billing
- Lack of documentation
- Incorrect Sequence Billing
- Incorrect coding
- Claim errors
- Medical necessity not met



Ambulance provider arrangements:

Instead of agreeing to pay based on if Medicare denies, SNFs may want to instead clarify that the SNF will pay only when policy states the SNF is responsible or if an error on the SNF billing for some reason blocks the provider from getting paid.

Example: the SNF forgetting the 74 code on an overnight absence claim. If Medicare does not have documentation of the skip day, the ambulance biller cannot get paid. If the SNF does not correct timely, then they may be held accountable.



What can be outlined in provider arrangements?

Provider arrangements should cover all interactions between both entities, from providing care to processing billing – including but not limited to:

- Timely billing cutoff – example: 12 months from DOS or recoup/denial date
- Acceptable proof of timely billing – example: fax/email received receipts, documented correspondence with a business office representative
- Acceptance of appropriate fee schedule rates – this would include outlining how a plan of care is submitted for review before services take place. Make sure providers are aware of the pre-arrangement REQUIREMENT of Consolidated Billing.
- Note any needed billing info– example: either a completed appropriate Medicare claim form or all required info on invoices.



How does a SNF create a provider arrangement?

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices>

The CMS Best Practices page offers examples and agreement templates for various provider types. Each template offers appropriate language for the type of provider, but these can be customized to suit the needs of each SNF/provider type and the care needs of residents, so long as Consolidated Billing regulations are not compromised.

Notice

This website provides sample agreements and communication tools for use by SNFs and their suppliers and practitioners. We are providing these samples in response to numerous requests for guidance. The use of the sample documents is not required. Providers, suppliers, and practitioners may choose to modify any of these documents to reflect more closely and accurately the realities of the parties' relationship. These documents only provide sample language, and CMS does not prescribe or endorse the use of any particular format or language.



How does a SNF create a provider arrangement?

SNF's Request for Ambulance Transportation For a Beneficiary in a Medicare Part A Stay (Sample Notification 2)

An SNF can provide this type of notification to an ambulance service transporting a beneficiary. Reflecting consolidated billing rules, this notice lays out the types of ambulance trips for which the ambulance service should bill Medicare directly and the types of ambulance trips which would require payment by the SNF to the ambulance service.

Locate the ambulance template on the CMS Best Practices page (Sample #2) and then scroll down to download

Downloads

- [Sample Notification 2 \(PDF\)](#)
- [Sample Notification 7 \(PDF\)](#)
- [Consolidated Billing Claims Processing Instructions \(PDF\)](#)
- [Sample Notification 3 \(PDF\)](#)
- [Sample Notification 4 \(PDF\)](#)
- [Sample Agreement 2 \(PDF\)](#)
- [Sample Notification 1 \(PDF\)](#)
- [Sample Notification 6 \(PDF\)](#)
- [Sample Agreement 1 \(PDF\)](#)
- [Sample Notification 5 \(PDF\)](#)



What if I need more help with my Consolidated Billing?



Where can I find CB help?

If you are having an issue with a provider claim, take the proper steps to try and resolve.

- Step One – Check the SNF billing to make sure all was done correctly on your end. LOA dates were recorded correctly, etc. Confirm with your MAC that all looks okay on the SNF side.
- Step Two – Contact your provider office to try and educate them on correct policy with documentation from the Medicare Claims Processing Manual. Escalate internally and request a check for possible errors on the provider end. Request they confirm their billing is correct with their MAC.
- Step Three – If you cannot resolve the issue with the provider and after involving your MAC, you can escalate to your local CMS office. CMS regional offices are displayed on CMS.gov, here:

<https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices>



Recap

- Identify Part A residents to providers before services are rendered and have terms of service in place for care and billing.
- Screen incoming claims for interruptions in Consolidated Billing – providers often bill the SNF in error during these paused periods.
- Be sure to correctly identify exclusions by statute as well as exclusions by circumstance and issue ABN's for non-covered charges.
- Make sure you are applying the most appropriate and current fee schedule based on your provider agreement.
- Be sure to not confuse ambulance transports with non-ambulance.
- Don't ever decide to pay or not pay a claim based on a remit – always go by CMS policy.



Questions?

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