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Skilled Nursing Facility (SNF) Consolidated Billing

Wednesday, May 21, 2025

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Agenda

- SNF Consolidated Billing background information
- Consolidated Billing requirements and the SNF's responsibilities
- Identify items/services excluded from Consolidated Billing
- Consolidated Billing scenarios

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Consolidated Billing Overview

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SNF Prospective Payment System (PPS)

- All skilled nursing facility (SNF) Part A inpatient services paid under a PPS.
- Under SNF PPS, beneficiaries must meet coverage requirements:
  - Must have inpatient hospital stay of at least 3 consecutive days
  - Be transferred to SNF within 30 days of hospital discharge
  - SNF services must be related to qualifying hospital stay
- All covered services within scope of the SNF are paid under PPS
  - SNF must obtain some services it does not provide directly
- Services cannot be billed under Part B unless excluded from PPS/Consolidated Billing
- Medicare Benefit Policy Manual, Chapter 8, Sections 10-20

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SNF Consolidated Billing: Background

- Prior to the Balanced Budget Act of 1997 (BBA), skilled nursing facilities (SNFs) could furnish services to residents in a covered part A stay either:
  - Directly, using its own resources
  - Through the SNF's hospital transfer agreement; or
  - Under the arrangements with independent therapist (for physical, occupational, and speech therapy services)
- SNF billed Medicare Part A for these services.
- SNFs could also "unbundle" a service altogether.
  - Outside supplier furnished the service directly to residents and bill Medicare Part B without SNF involvement.

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SNF Consolidated Billing: Background

- Per the Consolidated Billing (CB) requirement in Balance Budget Act of 1997, SNFs must submit all Medicare claims for the services that its residents receive.
  - Some services specifically excluded from CB
- SNFs can no longer “unbundle” services subject to CB so outside suppliers can separately bill Part B.
- The outside supplier must look to the SNF (rather than to Medicare) for payment
- CB provides a foundation for the SNF PPS by bundling all the services paid under the PPS into a single facility package.
- Eliminates possible duplicate claims for the same service from SNF and outside providers.
- Enhances the SNF’s ability to meet its responsibility to oversee and coordinate each resident's overall care.

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SNF Resident Status

- **SNF resident:** Beneficiary admitted to Medicare- participating SNF or participating Medicare- certified distinct part unit of larger institution.
- **Resident status ends when beneficiary:**
  - Admitted as an inpatient to a hospital, CAH or to another SNF
  - Receives services under a home health plan of care
  - Receives an outpatient service designated as exceptionally intensive
  - Formally discharged from SNF, unless admitted back to the SNF by midnight of same day
    - When beneficiary’s absence spans midnight, offsite services not subject to CB
  - Services provided during leave of absence (LOA) not subject to CB
    - **LOA:** patient out of facility at midnight census, but not discharged, for reasons other that hospital admission, other SNF admission, or distinct part unit of the SNF
- Medicare Claims Processing Manual, Chapter 6, Section 10.1

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Facilities Subject to Consolidated Billing

CB applies to:

- Participating SNFs
- Short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing-bed hospitals (excludes critical access hospitals)

CB does not apply to:

- A nursing home that is not Medicare-certified, such as:
  - A nursing home that does not participate at all in either the Medicare or Medicaid programs;
  - A non-certified part of a nursing home that also includes a participating distinct part SNF unit;
  - A nursing home that exclusively participates in the Medicaid program as a nursing facility

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Providers Impacted by Consolidated Billing

- Durable Medical Equipment (DME) suppliers
- Physicians
- Hospitals/Critical Access Hospitals (CAHs)
- Imaging and radiology centers
- Laboratories
- Ambulance companies
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

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SNF Responsibilities

- SNF must furnish services directly or under arrangements with outside providers.
- SNFs must bill for all Part A services residents receive.
  - Must also bill for physical therapy, occupational therapy, speech-language pathology during non-covered stay
  - Outside provider must look to SNF for payment.
- SNFs should document arrangements with other providers in writing, such as payment rates, timeframe for billing and payment, etc.
- SNFs must notify outside providers that a patient is in a SNF when they furnish services.
  - Best Practices Guidelines | CMS

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Services Under Arrangements

- SNFs must have arrangements in place with outside providers furnishing services.
- Agreement should specify:
  - Arranged-for services for which the SNF assumes responsibility
  - How SNF will pay outside provider/supplier
- The agreement does not have to be a formalized contract
  - **Sample Agreements:** Best Practices Guidelines | CMS
- Agreement is private contractual matter between SNF and outside provider.
  - Medicare does not impose any requirements
- Absence of a valid agreement does not invalidate SNFs responsibility to pay outside providers for services.
  - Medicare Claims Processing Manual, Chapter 6, Sections 10.4 and 80

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Consolidated Billing Inclusions/Exclusions

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Consolidated Billing Inclusions

- Services provided under arrangement
- Supplies
- Enteral and parenteral nutrition
- Certain ambulance services
- Labs and x-rays
- Certain orthotics and prosthetics
- Drugs and biologicals
- Services received in emergency room not for emergency treatment
- Therapy services (PT, OT, SLP) received during Part A or Part B stay

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Services Excluded from Consolidated Billing

CB exclusions for beneficiaries in a covered Part A stay:

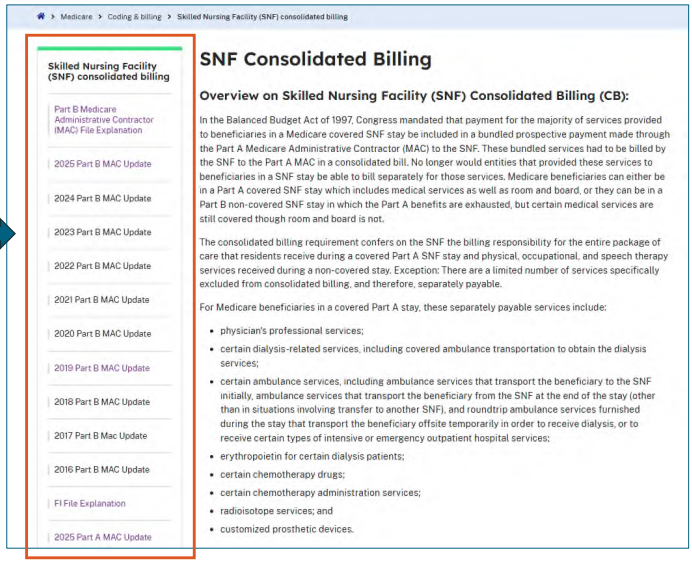
- Physician's professional services
- Certain dialysis- related services
- Certain ambulance services
- Erythropoietin for certain dialysis patients
- Certain chemotherapy drugs
- Certain chemotherapy administration services
- Radioisotope services
- Customized prosthetic devices
- For beneficiaries in a **NON-COVERED** stay, only therapy services are included in Consolidated Billing

MAC Update Files

- Annual update files have a complete list of HCPCS codes excluded from SNF CB. Minor surgery and Part B inclusions are also listed: https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing
- Files are updated annually
  - May also be updated as necessary through quarterly update process
- **How to access:**
  - Select the Part A or B MAC Update for the appropriate year on the left side of page.
  - Explanations of the latest updates to the files are included on the webpage.
  - For Part A , locate the Annual SNF Consolidated Billing HCPCS Update under Downloads and open the file.
  - For Part B, four files are listed under Downloads. Locate and open the appropriate file.

Accessing the MAC Update Files

Access list of HCPCS excluded from CB by clicking on the Part A/B MAC Update for the appropriate year.
CMS SNF Consolidated Billing



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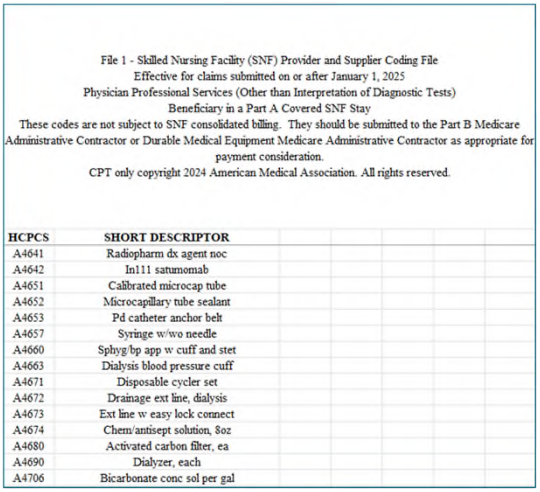
View Part B MAC Updates

To view listing of CB exclusions, select the appropriate file under Downloads on the Part B MAC Update webpage.

The files list codes excluded from CB.



File 1 - Skilled Nursing Facility (SNF) Provider and Supplier Coding File
Effective for claims submitted on or after January 1, 2025
Physician Professional Services (Other than Interpretation of Diagnostic Tests)
Beneficiary in a Part A Covered SNF Stay
These codes are not subject to SNF consolidated billing. They should be submitted to the Part B Medicare Administrative Contractor or Durable Medical Equipment Medicare Administrative Contractor as appropriate for payment consideration.
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HCPCS	SHORT DESCRIPTOR
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A4651	Calibrated microcap tube
A4652	Microcapillary tube sealant
A4653	Pd catheter anchor belt
A4657	Syringe w/wo needle
A4660	Sphyg/bp app w cuff and stet
A4663	Dialysis blood pressure cuff
A4671	Disposable cycler set
A4672	Drainage ext line, dialysis
A4673	Ext line w easy lock connect
A4674	Chem/antisept solution, 8oz
A4680	Activated carbon filter, ea
A4690	Dialyzer, each
A4706	Bicarbonate conc sol per gal

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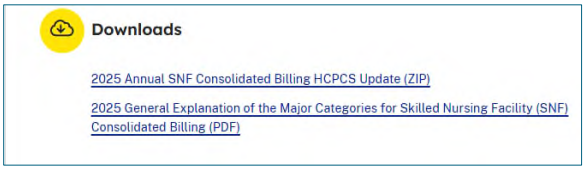
View Part A MAC Updates

To see a list of HCPCS excluded from CB, open the Annual SNF CB HCPCS Update file on the Part A MAC Update webpage.



The files list HCPCS excluded from CB. It also lists minor surgery and Part B therapy codes included in CB.

HCPCS		Short Description	Major Category
77011		CT STEREOSTATIC LOCALIZATION	Major Category I. A. - Computerized Axial Tomography (CT) Scans
77012		CT, NEEDLE PLACEMENT	Major Category I. A. - Computerized Axial Tomography (CT) Scans
77013		CT, PARENCHYMAL TISS ABLATION	Major Category I. A. - Computerized Axial Tomography (CT) Scans
77078		CT BONE MINERAL DENSITY, AXIAL SKELETON	Major Category I. A. - Computerized Axial Tomography (CT) Scans
77079		CT BONE MINERAL DENSITY, APPEND SKELETON	Major Category I. A. - Computerized Axial Tomography (CT) Scans
29580		PASTE/UNNA BOOT	Major Category V. A. - Therapies - INCLUSION
29581		LOWER EXTREMITY APPLICATION OF STRAPPING	Major Category V. A. - Therapies - INCLUSION
29584		APPLICATION OF MULTI COMPRESSION SYSTEMS	Major Category V. A. - Therapies - INCLUSION
90901		BIOFEEDBACK TRAIN, ANY METH	Major Category V. A. - Therapies - INCLUSION

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Major Categories

- CMS divided the services affected by SNF Consolidated Billing into five Major Categories.
- The General Explanation of the Major Categories provides detailed information about Consolidated Billing inclusions and exclusions:
  - https://www.cms.gov/files/document/general-explanation-major-categories-skilled-nursing-facility-snf-consolidated-billing.pdf
- The Major Categories are important to understand so services are billed appropriately.
  - Some Major Categories exclude services by revenue code or bill type.
    - Example: Emergency room services or renal dialysis and hospice facilities.
- Major Category Information: Medicare Claims Processing Manual, Chapter 6

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Major Category I

Exclusions of Services Beyond the Scope of SNF

- Services must be furnished on outpatient basis in a hospital. Excluded from SNF PPS and CB for beneficiaries in a Part A stay.
- **Category I subcategories:**
  - **A-** CT scans
  - **B-** Cardiac Catheterization
  - **C-** MRI
  - **D-** Radiation Therapy
  - **E-** Angiography, Lymphatic, Venous, and Related Procedures
  - **F-** Outpatient Surgery and Related Procedures- **Inclusion**
  - **G-** Emergency Services
  - **H-** Ambulance Trips (related to excluded service)
  - **I-** Additional Surgery HCPCS
    - Additional surgery exclusions not within outpatient surgery HCPCS ranges 0001T-0021T, 0024T-0026T, or 10021-69990

Ambulance Service Inclusions

Ambulance trips are INCLUDED in Consolidated Billing in the following situations:

- Transfer between two SNFs
  - Day of departure from SNF 1 is a covered Part A day **if** admission to SNF 2 is before the following midnight. Both SNF transfer and ambulance trip must be medically necessary
- Transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility
  - Examples: cancer treatment center, radiation therapy center, wound care center
- Roundtrip to a physician's office

Ambulance services must meet medical necessity requirements for coverage

- Non-ambulance transport not covered by Medicare
- Medicare Benefit Policy Manual, Chapter 10: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c10.pdf

Ambulance Service Exclusions

Ambulance trips may be separately billed to Part B by the ambulance company if:

- The trip is to the SNF for admission or from the SNF to the beneficiary's home after discharge
- The trip is to or from the hospital or non-hospital based ESRD facility for the purpose of receiving dialysis and related services
- The trip is from the SNF to a hospital or CAH for admission
- The trip follows beneficiary's discharge or other departure from a SNF to a destination other than another SNF and they do not return before the following midnight
- The beneficiary goes to a hospital to receive emergency or other excluded services and returns to the SNF
  - Medicare Claims Processing Manual, Chapter 6, Section 20.3.1

Major Category II

Additional Services Excluded when Rendered to Specific Beneficiaries

- Includes services provided to beneficiaries with End Stage Renal Disease (ESRD) or beneficiaries who elected hospice and are excluded from SNF PPS and CB
- Category II subcategories:
  - A- Dialysis, EPO, Aranesp, and Other Dialysis Related Services for ESRD beneficiaries
    - Specific coding identifies dialysis and related services excluded from CB for ESRD beneficiaries for:
      - Services provided in renal dialysis facility
      - Home dialysis services when the SNF is considered the patient's home
      - EPO or Aranesp is used along with dialysis for ESRD beneficiaries
    - Medicare Claims Processing Manual, Chapter 17, Section 80.9
  - B- Hospice Care for Beneficiary's Terminal Illness
    - Identified with bill types 81X or 82X

Major Category III

- Additional Excluded Services Rendered by Certified Providers
- Services may be provided by any Medicare provider licensed to provide them except a SNF. Excluded from SNF PPS and CB
- Category III subcategories:
  - **A-** Chemotherapy
    - Only certain chemotherapy drugs not typically administered in a SNF are excluded
  - **B-** Chemotherapy Administration
    - Codes with an asterisk (*) on the MAC Update file are excluded if billed with an excluded chemotherapy agent on same date of service but included in CB if performed alone or with other surgery. Must be billed with a chemotherapy agent. Physician orders to support chemotherapy must exist.
    - Codes without an asterisk are excluded surgery codes and may be billed without a chemotherapy agent **for hospital settings only.** For all other providers, codes without an asterisk are treated the same as those with an asterisk.
  - **C-** Radioisotopes
  - **D-** Customized Prosthetic Devices
  - **E-** Certain blood clotting factors for treating hemophilia and other bleeding disorders and related items and services

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Major Category IV

Additional Excluded Preventive and Screening Services

- Services are covered under Part B and not included in SNF PPS but still subject to CB.
- Are billed by SNF on 22X bill type. Swing beds use 12X bill type
- **Category IV subcategories:**
  - 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 Preventive Physical Exam
  - K- Abdominal Aortic Aneurysms Screening
    - Preventive service coverage/billing: Medicare Claims Processing Manual, Chapter 18

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Major Category V

Part B Services Included in SNF CB

- Therapy services included in SNF PPS and CB for beneficiaries in a Part A stay.
- Must also be billed by the SNF for Part B residents as they fall under the SNF Part B CB requirement (for services furnished to SNF residents in noncovered stays)
  - Billed on 22X bill type
  - For residents in non-skilled level of care moved out of SNF to Medicare non-certified area of facility: billed on 23X bill type
- Therapy revenue codes:
  - Physical therapy: 42X
  - Occupational therapy: 43X
  - Speech-language pathology: 44X

Consolidated Billing Scenarios

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SNF's Responsibilities

- SNFs should ensure other providers know that a patient is in a covered SNF stay.
  - Should have arrangements in place with outside providers
- Communicate with beneficiaries/representatives about SNF CB.
  - Some services must be billed to Medicare by the SNF
  - SNFs are responsible for coordinating the beneficiary's care
  - Responsible for billing for services even if an arrangement is not in place

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Provider Responsibilities

- Best way to avoid billing issues is to communicate with the beneficiary and SNF
- Ask patients/representatives if they are in a SNF stay
- Check with SNF
- Develop screening procedures for determining if patients are in SNF
- Check Medicare eligibility:
  - myCGS User Manual
  - Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)

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Scenario 1

- A SNF has an outside provider furnish services to their patient in a Part A covered stay.
- The provider is unaware that the patient is in a Part A stay, and that the services are subject to CB

Resolution: Scenario 1

SNF action:

- Must reimburse the provider and bill Medicare for services
- The SNF should notify other providers when patients are in a Part A stay and if services included in CB
- Have written agreement in place to avoid disputes and ensure proper billing

Outside provider:

- Providers should determine if patient is in a SNF and contact SNF prior to furnishing services
- Once it is determined the services are subject to CB, bill the SNF

Scenario 2

- A SNF resident, while briefly away from the SNF, receives services from a non-SNF provider.
- The SNF resident does not notify the SNF of the services received.
- The SNF does not pay the outside provider.

Resolution: Scenario 2

SNF action:

- SNF is responsible for services included in CB and must reimburse the outside provider.
- Communicate with patients that SNFs must coordinate all services they receive
- Let residents know they should notify the SNF when receiving offsite services.

Outside providers:

- Submit charges to the SNF for reimbursement
- Determine if the patient is in a Part A SNF stay before providing services
- Contact SNF before services are provided

Scenario 3

- A SNF resident receives a CT scan (HCPCS 73201) during a Part A SNF stay.
- The service was provided at an outpatient hospital location.
- The hospital is not sure if the SNF is responsible for the service.

Resolution: Scenario 3

- Providers can check the MAC Update files to see if the HCPCS code is listed.
  - Since this is a hospital provider, the Part A files should be checked.
    - For Part B providers, check Part B MAC Updates
  - HCPCS 73201 is listed in the 2025 Part A file. This indicates it is excluded from CB and can be billed to Medicare by the hospital
- Providers should also refer to The General Explanation of the Major Categories. CT scans are under Major Category 1, indicating it is excluded from CB when provided in a hospital.

Scenario 4

- A SNF resident in a Part A stay is transported by ambulance to and from a radiation therapy center. The ambulance transport was medically necessary.
- The SNF receives a bill from the ambulance company.

Resolution: Scenario 4

- SNFs and other providers can check the Medicare Claims Processing Manual, Chapter 6, Section 20.3.1 for detailed information regarding ambulance services/CB.
- Based on the manual, ambulance transports to and from a therapeutic site other than a hospital or renal dialysis facility are included in SNF CB.
- The SNF is responsible for billing the service to Medicare.
- The ambulance must look to the SNF for payment.

Medicare Updates, Resources, and Contact Information

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FY 2026 SNF PPS Proposed Rule

CMS issued proposed rule to update FY 2026 SNF PPS payment policies/rates.

Major provisions:

- CMS requesting information on streamlining and reducing administrative burdens in Medicare:
  - https://www.cms.gov/medicare-regulatory-relief-rfi
- FY 2026 proposed updates to SNF payment rates
  - Update PPS rates by 2.8% based on proposed market basket rate of 3.0%, plus 0.6% market basket forecast error adjustment, and negative 0.8% productivity adjustment.
- Updates to Value-Based Purchasing Program
- SNF Quality Reporting Program updates
  - Proposal to remove four standardized patient assessment data elements

Comments due by June 10

- **Summary of proposed provisions:** https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2026-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1827-p-fact

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2025 DDE & PPTN Recertification

- CGS is required to certify each DDE and PPTN user's access annually.
- To avoid service interruptions:
  - Complete the Annual DDE PPTN Recertification Form
  - List all users
  - If you have more than 10 users, please submit additional forms
  - Fax the completed forms to CGS:
    - Part A: 615-664-5943
    - Part B: 615-664-5917
    - HH&H: 615-664-5947
- Part A providers can send recertification forms beginning July 1, 2025. Deadline for form submission is July 31, 2025.

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Reminder: Duplicate Appeals

- CGS is seeing an increase in duplicate appeal (redetermination) submissions.
  - Appeals can only be processed once at each level
- To prevent multiple submissions of the same redetermination:
  - Check appeal status to determine if an appeal is already on file:
    - myCGS web portal
    - Interactive Voice Response System (IVR): 1.866.289.6501
- Allow 60 days from the date of receipt of the redetermination for decision
- If you've received a redetermination decision and disagree with the outcome, do not submit another redetermination. Instead, request a second-level appeal (reconsideration): https://cgsmedicare.com/parta/appeals/level2.html

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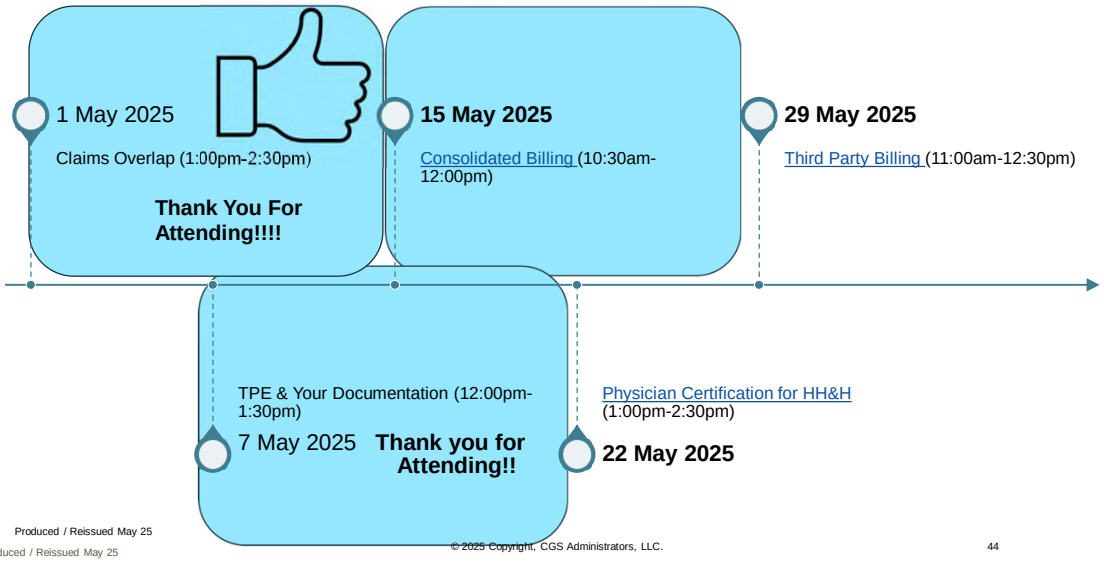
Resources

- Medicare Benefit Policy Manual, Chapter 8- SNF Coverage: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf
- Medicare Claims Processing Manual, Chapter 6- SNF PPS and CB: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf
- Consolidated Billing (CMS) https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing
- Medicare Learning Network SNF Billing Reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/snf/index.html

Register for the Remaining Roundtable Talks



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Upcoming CGS Events

- May 27: The DDE Claims Correction Menu
- June 3: Computer Telephony Integration (CTI)
- June 17: What's New With myCGS?
- June 19: Welcome to Medicare
- July 22: Navigating the Recovery Audit Contractor (RAC) Process

Register:
https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/partA_report/parta_report.aspx

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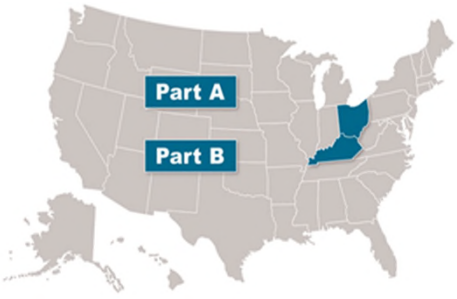
Contact CGS Provider Outreach & Education

- Part A: J15_PartA_Education@cgsadmin.com
- Part B: J15_PartB_Education@cgsadmin.com
- HHH: J15_HHH_Education@cgsadmin.com

We are here for your educational needs!!



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Quality Summit: Session 3: Skilled Nursing Facility (SNF) Consolidated Billing: An Overview
Speaker Evaluation Form

May 21

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3. **Tap the notification to open the link (Internet connection required)**
4. **Follow the instructions on the link to complete the training evaluation**
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Please note that you will be required to enter your KBN license number.

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