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5 Major Categories
Skilled Nursing Facility(SNF) Consolidated Billing

The SNF annual update file contains a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing). The CMS has divided these codes into 5 Major Categories.

Major Category I	Exclusion of Services Beyond the Scope of a SNF
Major Category II	Additional Services Excluded when Rendered to Specific Beneficiaries
Major Category III	Additional Excluded Services Rendered by Certified Providers
Major Category IV	Additional Excluded Preventive and Screening Services
Major Category V	Part B Services Included in SNF Consolidated Billing

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Major Category I: 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 Consolidated Billing 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 Consolidated Billing, with exceptions as listed below.

- Note that **anesthesia, drugs** incident to radiology and supplies (**revenue codes 037x, 025x, 027x and 062x)** will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.

- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery **HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed as inclusions under Major Category I.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).

Services billed by providers to the Fiscal Intermediary/Medicare Administrative Contractor represent the facility charge portion for those services.

Major Category I 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 (Inclusions)

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

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.

G. Emergency Services

These services are identified on claims submitted to Fiscal Intermediary/Medicare Administrative Contractor by a hospital or Critical Access Hospital (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 to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.

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.

H. Ambulance Trips – With Application to Major Category II

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

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

A. Computerized Axial Tomography (CT) Scans	B. Cardiac Catheterization	C. Magnetic Resonance Imaging (MRI)
70450	33967–33968	70336
70460	93451–93464	70540
70470	93503	70542–70549
70480–70482	93505	70551–70555
70486–70488	93530–93533	70557–70559
70490–70492	93561–93562	71550–71552
70496	93563–93564	71555
70498	93571–93572	72141–72142
71250	93600	72146–72149
71260	93602–93603	72156–72158
71270	93609–93610	72195–72198
71275	93612–93613	73218–73223
72125–72133	93615–93616	73718–73723
72191–72194	93618–93624	73725
73200–73202	93631	74181–74183
73206	93640–93642	74185
73700–73702	93644	75557–75563
73706	93650	76390
74150	93653–93657	76498
74160	93660	77021–77022
74170	93662	77058–77059
74174		77084
74175		C8900–C8914
74176–74178		C8918–C8920
74261–74262		
75635		
76380		
76497		
77011–77013		
77078–77079		

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

D. Radiation Therapy		E. Angiography, Lymphatic, Venous and Related Procedures	
19296–19297	77499	36598	75809–75810
77261–77263	77520	75600	75820
77280	77522–77523	75605	75822
77285	77525	75625	75825
77290	77600	75630	75827
77293	77605	75635	75831
77295	77610	75650	75833
77299	77615	75658	75840
77300–77301	77620	75660	75842
77305	77750	75662	75860
77310	77761–77763	75665	75870
77315	77776–77778	75671	75872
77321	77781–77784	75676	75880
77326–77328	77789–77790	75680	75885
77331–77334	77799	75685	75887
77336	A4648	75705	75889
77338	A4650	75710	75891
77370–77371	C1715–C1719	75716	75893–75894
77372–77373	C1728	75722	75896
77399	C2616	75724	75898
77401–77404	C2634–C2637	75726	75900
77406–77409	C2639	75731	75940
77411–77414	C2641	75733	75961–75962
77416–77418	C2643	75736	75964
77421	C9725	75741	75966
77427	G0173	75743	75968
77431–77432	G0251	75746	75970
77470	G0339–G0340	75756	75978
		75774	75980
		75790	75982
		75801	75992–75996
		75803	G0269
		75805	G0275
		75807	G0278

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

F. Outpatient Surgery and Related Procedures

HCPCS codes 0001T–0021T, 0024T–0026T, or 10021–69990 are exempt from consolidated billing and should be billed directly by the facility except for the following codes representing minor procedures that can be performed in the SNF itself. This includes all other revenue code lines on the incoming claim that have the same line-item date of service (LIDOS). Ambulatory surgeries performed at freestanding or nonhospital ASCs are not exempt from SNF consolidated billing. When the patient is in a SNF Part A stay, the ASC must bill and seek reimbursement from the SNF. Claims from freestanding or nonhospital ASCs will be denied and any payments made will be recouped. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 6, sec.110.2.7)

10040	29105	36405–36406
10060	29125–29126	36430
10080	29130–29131	36468–36471
10120	29200	36600
11040–11041	29220	36620
11055–11057	29240	36680
11100–11101	29260	37195
11200–11201	29280	51701–51703
11300	29345	51772
11305	29355	51784–51785
11400	29358	51792
11420	29365	51795
11440	29405	51797–51798
11719–11721	29425	53601
11740	29435	53660–53661
11900–11901	29440	54150
11920–11922	29445	54235
11950–11952	29450	54240
11954	29505	54250
11975–11977	29515	55870
15780–15783	29520	57160
15786–15789	29530	57170
15792–15793	29540	58301
16000	29550	58321
16020	29580	58323
17000	29590	59020
17003–17004	29700	59025

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

F. Outpatient Surgery and Related Procedures (continued)		
HCPCS codes 0001T–0021T, 0024T–0026T, or 10021–69990 are exempt from consolidated billing and should be billed directly by the facility except for the following codes representing minor procedures that can be performed in the SNF itself. This includes all other revenue code lines on the incoming claim that have the same line-item date of service (LIDOS). Ambulatory surgeries performed at freestanding or nonhospital ASCs are not exempt from SNF consolidated billing. When the patient is in a SNF Part A stay, the ASC must bill and seek reimbursement from the SNF. Claims from freestanding or nonhospital ASCs will be denied and any payments made will be recouped. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 6, sec.110.2.7)		
17003–17004 17110–17111 17250 17340 17360 17380 17999 20000 20526 20550–20553 20974 20979 21084–21085 21497 26010 29058 29065 29075 29085–29086	29700 29705 29710 29715 29720 29730 29740 29750 29799 30300 30901 31720 31725 31730 32550–32551 36000 36002 36140 36400	59025 59425–59426 59430 62367–62368 65205 69000 69200 69210 91123 92977 95970–95975 95990 99183 G0127 G0168 G0268 G0293–G0294

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Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)

G. Emergency Services	H. Ambulance Trips
Emergency services are excluded from consolidated billing when submitted to FIs by a hospital CAH using RC 045X. 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. When an ER encounter spans multiple dates of service, the actual date of service is reported for related services. These related services must have modifier ET appended to them to indicate that they are related to the exempt ER encounter.	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 (RDF) are also excluded from SNF consolidated billing. A0425–A0436 A0999

I. Additional Surgery HCPCS Exclusions
C9600–C9608 G0186 G0289 G0299–G0300 G0342–G0343 G0364 92928–92929 92933–92934 92937–92938 92941

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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.

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 I. 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.

SNFs may not be paid for home dialysis supplies.

Providers/Suppliers may bill their intermediary or carrier for an ESRD-related diagnostic test, provided the test is outside of the ESRD-facility composite rate. The use of the "Consolidated Billing" modifier would allow these services to be bypassed from the SNF Consolidated Billing edits. Please refer to Change Request 2475 for greater detail.

1. Coding Applicable to Services Provided in a RDF or SNF as Home

Institutional dialysis services billed only by a RDF are identified by **type of bill 72X**. Services for Method 1 and 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related **diagnosis code 585.6.**

2. The applicable HCPCS codes are identified in the excel file as **Dialysis Supplies** and **Dialysis Equipment.**

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Major Category II: Additional Services Excluded when Rendered to Specific Beneficiaries (continued)

3. Coding Applicable to EPO and Aranesp Services

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by ESRD beneficiaries. Darbepoetin alfa (trade name Aranesp) is a drug Medicare approved for use by ESRD beneficiaries.

When epoetin alfa or darbepoetin alfa are given by the dialysis facility in conjunction with dialysis, **these drugs are excluded** and **must be billed by the RDF**. Instructions for billing RDF services are in publication 100-4, chapter 8.

To distinguish epoetin alfa or darbepoetin alfa given to ESRD beneficiaries from the same drugs given to non-ESRD beneficiaries CMS has developed separate codes. The instructions for billing for non-ESRD epoetin alfa or darbepoetin alfa are located in publication 100-4, chapter 17, section 80.9.

These drugs for non-ESRD use are always bundled to the SNF for beneficiaries in a covered Part A stay.

B. Hospice Care for a Beneficiary's Terminal Illness

Hospice services for terminal conditions are identified with the following **bill types: 81X or 82X.**

Services provided to ESRD beneficiaries, or to beneficiaries who have elected Hospice provided by licensed Medicare Hospice providers are excluded from SNF PPS and consolidated billing. ESRD services provided within the SNF are included in the SNF payment. ESRD services (category IIA) are separately reimbursable only when provided in a renal dialysis facility (TOB 072X) or as home dialysis to patients whose home is the SNF. SNFs may not be paid directly for home dialysis supplies. Hospice services are reimbursable only when billed by a Hospice provider (TOB 081X or 082X).

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Major Category II: Additional Services Excluded when Rendered to Specific Beneficiaries (continued)

A. Dialysis, Epoetin, Darbepoetin, and Other Dialysis Related Services for ESRD Beneficiaries

When the epoetin or darbepoetin are used for ESRD beneficiaries, the RDF or hospital may bill for them using codes J0882, J0886, and Q4081. ESRD supplies billable by the RDF and excluded from consolidated billing are listed below.

A4651–A4653	A4870
A4657	A4890
A4660	A4911
A4663	A4913
A4671–A4674	A4918
A4680	A4927–A4931
A4690	E1500
A4706–A4709	E1510
A4714	E1520
A4719–A4726	E1530
A4728	E1540
A4730	E1550
A4736–A4737	E1560
A4740	E1570
A4750	E1575
A4755	E1580
A4760	E1590
A4765	E1592
A4766	E1594
A4770–A4774	E1600
A4802	E1610
A4860	E1615
	E1620
	E1625
	E1630
	E1632
	E1635–E1637
	E1639
	E1699
	J0884

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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 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

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

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Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)

A. Chemotherapy	
J0894	J9299
J9000	J9300
J9015	J9302
J9017	J9303
J9019	J9305
J9020	J9306
J9025	J9307–J9308
J9027	J9310
J9032–J9033	J9315
J9034–J9042	J9320
J9043	J9325
J9045	J9328
J9047	J9330
J9050	J9340
J9055	J9351
J9060	J9352
J9065	J9354
J9070	J9355
J9098	J9357
J9100	J9360
J9120	J9370
J9130	J9371
J9145	J9390
J9150–J9151	J9395
J9160	J9400
J9171	J9600
J9176	Q2050
J9178–J9179	
J9181	
J9185	
J9200–J9201	
J9205–J9207J9208	
J9211	
J9225	
J9228	
J9230	

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Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)

A. Chemotherapy (continued)	
J9245 J9261 J9263–J9264 J9268 J9270–J9271 J9280 J9293 J9295	

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Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)

B. Chemotherapy Administration	C. Radioisotopes and their Administration
Chemotherapy administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for Part A stay when performed alone or with other surgery. These services are excluded from consolidated billing and separately reimbursable when they occur with the same LIDOS as an excluded chemotherapy agent. Codes that do not have an asterisk (*) are excluded surgery codes for hospitals, including CAHs, and may be billed without a chemotherapy agent. 36260*–36262* 36555–36558 36560–36561 36563 36565–36566 36568–36571 36575–36576 36578 36580–36585 36589–36590 36595–36597 36640* 36823* 96401–96402* 96405*–96406* 96409* 96411* 96413* 96415*–96417* 96420* 96422*–96423* 96425* 96440* 96445* 96446 96450* 96521–96523	78804 77014 77750 77761–77763 77776–77778 77785–77787 77789–77790 77799 79005 79101 79200 79300 79403 79440 79445 A9530 A9542–A9543 G3001 **D. Customized Prosthetic Devices** CMS is clarifying the definition of customized DME. The agency believes that customized items are rarely necessary and are rarely furnished. In accordance with a longstanding definition in 42 CFR, Section 414.224, in order to be considered a customized item, a covered item (including a wheelchair) must be uniquely constructed or substantially modified for a specific patient according to the description and orders of a physician. It is expected to be a one-of-a-kind item fabricated to meet specific needs. The Omnibus Budget Reconciliation Act (OBRA), November 5, 1990, amended the criteria for treatment of wheelchair as a customized item. This alternative definition of customized wheelchairs was never adopted for Medicare payment purposes and should not be confused with the definition of customized items referenced above.

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Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)

B. Chemotherapy Administration	C. Radioisotopes and their Administration
96542* C8957* Q0083*-Q0085*	D. Customized Prosthetic Devices (continued) Payment is made for the lump sum purchase of the item based on the contractor's individual consideration and judgment of a reasonable payment amount for each customized item. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 20, sec.30.3; *Medicare Program Integrity Manual*, Pub. 100-08, chap. 5, sec. 5.15)

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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.

Chapter 18 "Preventive and Screening Services" of the Claims Processing Manual provides further coverage and billing guidance.

A. Mammography
B. Vaccines (Pneumococcal, Flu or Hepatitis B)
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

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Major Category IV: Additional Excluded Preventive and Screening Services (continued)

A. Mammography 77052 77057 G0202	B. Vaccines (Pneumococcal, Flu or Hepatitis B) 90654 90656–90657 90660 90662 90674 90760 90732 90740 90743–90744 90746–90747 Q2033 Q2035–Q2039
C. Vaccine Administration 90465–90468 G0008–G0010	D. Screening Pap Smear and Pelvic Exams G0101 G0123 G0143–G0145 G0147–G0148 P3000 Q0091
E. Colorectal Screening Services 82270 G0104 G0105 G0106 G0120 G0121 G0328 F. Prostate Cancer Screening G0102–G0103 G. Glaucoma Screening G0117–G0118 H. Diabetic Screening 82947 82950–82951	

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Major Category IV: Additional Excluded Preventive and Screening Services (continued)

I. Cardiovascular Screening 80061 82465 83718 84478 J. Initial Preventative Physical Exam G0344 G0367 K. Abdominal Aortic Aneurysm (AAA) Screening 76706	

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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**.

Therapies billed with revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology) must be billed by the SNF for all SNF patients whether or not the patient is in a Part A covered stay. These therapies include:

64450 90901 92507–92508 92520-92524 92526 92597 92605–92612 92614 92616 95831–95834 95851–95852 95992 96105 96110–96111 96115 96125 97010 97012 97016 97018 97022 97024 97026 97028 97032–97036 97039 97110 97112–97113 97116 97124 97139–97140	**Physician Services** Many physician services include both a professional and a technical component, and the technical component is subject to consolidated billing. The technical component of physician services must be billed to and reimbursed by the SNF. (http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp) The professional component of physician services and services of certain non- physician practitioners, excluding therapy providers, are excluded from the SNF Part A PPS payment and the requirement for consolidated billing. These professional services must be billed separately by the practitioner to the carrier. This policy applies to the professional component of services rendered by: l Physicians, other than physical, occupational, and speech-language pathology services l Physician assistants, working under a physician's supervision l Nurse practitioners and clinical nurse specialists working in collaboration with a physician l Certified nurse-midwives l Qualified psychologists l Certified registered nurse anesthetists The technical component of the hospital- based physician service is also exempt when billed on a TOB of 013X or 085X. HCPCS codes 99201–99245 or G0463 must be reported under revenue code 0510 for this exemption. Critical access hospitals billing under method II report the professional fees on TOB 085X using revenue code 096X, 097X, or 098X. The specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing. When a SNF's Part A resident receives the services of a physician or non-physician practitioner (as listed above) from a rural health clinic (RHC) or a federally qualified health center (FQHC), those services are not subject to consolidated billing because they are furnished by the RHC or FQHC. This subset of RHC or FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 071X and 077X, respectively, to bill for these RHC or FQHC services.

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Major Category V: Part B Services Included in SNF Consolidated Billing (continued)

	Physician Services (continued *Medicare Claims Processing Manual*, Pub. 100-04, chap. 6, secs. 20.1.1-20.1.1.2 97150 97161–97168 97530 97532–97533 97535 97537 97542 97597–97598 97602 97605–97608 97610 97750 97755 97760–97762 97799 0019T 0029T G0281 G0283 G0329 G8978-G8999 G9158-G9176 G9186 (website: http://www.cms.gov/SNFConsolidatedBilling/01_Overview.asp)