

GENERAL EXPLANATION OF THE MAJOR CATEGORIES FOR SNF CONSOLIDATED BILLING

GENERAL EXPLANATION OF THE MAJOR CATEGORIES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING

The SNF annual update file and the subsequent quarterly updates at <http://www.cms.hhs.gov/providers/snfpps/snffi/> contain a comprehensive list of HCPCS codes involved in editing claims submitted for services subject to SNF consolidated billing (CB). These codes are divided into 5 Major Categories.

General explanation of the Categories:

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), **not by a SNF**, and are excluded from SNF PPS and CB for beneficiaries in a covered SNF 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.

- 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).

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

**GENERAL EXPLANATION OF THE MAJOR CATEGORIES FOR SKILLED NURSING FACILITY (SNF)
CONSOLIDATED BILLING (CONTINUED)****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**. Additionally, this was the approach originally taken in regulation to present this information. *Procedures associated with splints and casts are included with minor surgical procedures and appear with an asterisk (*)*.

G. Emergency Services

These services are identified on claims submitted to FIs 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.

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.

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. *Note that SNFs may not be paid for home dialysis supplies.*

GENERAL EXPLANATION OF THE MAJOR CATEGORIES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CONTINUED)

Note: 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 "CB" modifier would allow these services to be bypassed from the SNF CB edits. Please refer to CMS Change Request 2475 for greater detail.

1. Coding Applicable to Services Provided in a RDF

Institutional dialysis services billed only by a RDF are identified by **type of bill 72X**. Services for Method 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related **diagnosis code 585**.

1. and 2. Coding Applicable to Services Provided in a RDF or SNF as Home

RDFs, or suppliers only when billing for home dialysis services for beneficiaries who reside in the SNF, use the following **revenue codes** for such billing:

- **825** - Hemodialysis OPD/Home Support Services
- **835** - Peritoneal OPD/Home Support Services
- **845** - Continuous Ambulatory Peritoneal Dialysis OPD/HomeSupport Services
- **855** - Continuous Cycling Peritoneal Dialysis OPD/HomeSupport Services

Note: HCPCS codes recognized for use with these revenue codes are identified in the excel file as **Dialysis Supplies** and **Dialysis Equipment**.

3. Coding Applicable to EPO and Aranesp Services

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by ESRD beneficiaries. Intermediary Epoetin alfa claims for ESRD beneficiaries are identified with the following **revenue codes when services are provided in RDF:**

- 634** - EPO with less than 10,000 units)
- 635** - EPO with 10,000 or greater units)

Darbepoetin alfa (trade name Aranesp) is a drug Medicare approved for use by ESRD beneficiaries. Darbepoetin alfa will always be billed in revenue code 636. The HCPCS code for darbepoetin alfa for ESRD beneficiaries is **Q4054**. When epoetin alfa or darbepoetin alfa are given by the dialysis facility in conjunction with dialysis, these drugs are excluded.

In addition, a new Q code has been approved for EPO for ESRD beneficiaries, **Q4055**. This code is also billed in **revenue code 636**.

GENERAL EXPLANATION OF THE MAJOR CATEGORIES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CONTINUED)

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. Epoetin for non-ESRD beneficiaries is shown with HCPCS code **Q0136**, and darbepoetin alfa for **non-ESRD** beneficiaries is shown with HCPCS code **Q0137**. These codes, like those for ESRD beneficiaries are billed in **revenue code 0636**. These non-ESRD codes (Q0136 and Q0137) 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**.

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 without an asterisk (*) are excluded surgery codes for hospitals, including CAHs, and may be billed without a chemotherapy agent.

C. Radioisotopes and their Administration

D. Customized Prosthetic Devices

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.

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Note for Medicare Contractors: Please access Chapter 18 "Preventive and Screening Services" of the Claims Processing manual for 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

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 and non-residents.

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

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