

General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing

The SNF annual update file contains a comprehensive list of HCPCS codes involved in editing institutional claims submitted to A/B MACs for services subject to SNF consolidated billing (CB). The CMS has divided these codes 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) only, not by a SNF, and are excluded from SNF PPS and CB 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 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 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).

NOTE: Services billed by providers to the 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– 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.

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.

I. Additional Surgery HCPCS – EXCLUSIONS

These services are additional surgery exclusions that do not fall within the Outpatient Surgery HCPCS codes ranges 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed as inclusions under Major Category I.F)

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 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.*

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. ESRD beneficiaries billed by an RDF must be accompanied by the dialysis related diagnosis code N18.6.

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

2. 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.

NOTE: 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 located 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.

NOTE: 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.

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.

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

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)