CHAPTER 8
ADDENDUM E

PROGRAM MEMORANDUM INTERMEDIARIES

Program Memorandum Intermediaries

**Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)**

Transmittal A-02-118 **Date: NOVEMBER 8, 2002**

CHANGE REQUEST 2459

SUBJECT: Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement, Updated SNF Help File

I. GENERAL INFORMATION

A. Background:

In several past Program Memoranda (PM), CMS established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the Skilled Nursing Facility Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs), will not be paid by Medicare to providers, other than a SNF, when included in SNF CB on dates when a beneficiary for whom such a service is being billed resides in a SNF. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

Beginning with this PM, CMS aims to establish a routine and comprehensive process for updating SNF CB edits affected by HCPCS coding changes in each quarter in a clearly designated PM. This PM is the first quarterly SNF consolidated billing update for Fiscal Year (FY) 2003. It incorporates new temporary codes (such as K codes), as well as the annual update of all HCPCS codes. Therefore, this PM is referred to as an annual update. Other updates for the remaining quarters of the FY will occur as needed due to the creation of new temporary codes representing services subject to SNF CB prior to the next annual update.

The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is,

new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined.

A revised SNF Help File in Excel is also attached, with a separate "Readme" file in Word to provide guidance. This file was developed to provide billing guidance to FIs, SNFs and suppliers on HCPCS codes including and exceeding those codes affected by SNF CB. In total this file contains several thousand code entries, and therefore is transmitted from CMS to FIs as a zipped file.

Any misstatements, which appear in the "Comments" column of the File, will be addressed in transmittals on update versions of the Help File. The SNF Help File is furnished with the electronic copy only. It can be accessed at http://www.cms.hhs.gov/manuals. Select Program Memos, then select the transmittal for this PM: A-02-118, then select the link to the Attachment: A02_118a.zip for Help File. The Readme section of this attachment will explain how to use the Help File, which is in Excel.

B. Policy:

Section 1888 of the Social Security Act codifies SNF PPS and CB.

II. BUSINESS REQUIREMENTS

Req. #	Requirements	Resp.
xxxx.1	The Common Working File (CWF), part of Medicare claims processing systems, must use the attached list of codes to enforce existing SNF CB edits on claims submitted on or after January 1, 2003. **[Systems Requirement]**	CWF
xxxx.2	Medicare FIs must publish the new list of codes subject to SNF CB (attached), and otherwise notify their providers of changes to SNF consolidated billing through their Web sites FIs within two weeks after publication of this PM and their next available provider bulletin. **[Non-systems Requirement]**	FIs
xxxx.3	FIs must discard previous SNF Help and Readme Files furnished with PMs A-01-135, AB-02-027, and AB-2-043, and replace those files with the versions attached to this PM. [Note that PMs A-01-135, AB-02-027, or AB-02-043 related to the Help File will not be re-issued, and that differences between this and the previous version of the Help File are highlighted in the updated Readme file.] **[Non-systems Requirement]**	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A - Other Instructions:

X-Ref Req. #	Instructions
	N/A

B - Design Considerations: N/A
C - Interfaces: N/A
D - Contractor Financial Reporting/Workload Impact: N/A
E - Dependencies: N/A
F - Testing Considerations: N/A/

IV. ATTACHMENT(S)

SNF CB HCPCS Coding List with README for Help File (in Word integrated into this PM)

SNF Help File (a separate Zipped Excel file, A02_118a.zip) **SNF HCPCS Help File**

Version: **Implementation Date:** Systems Changes: January 1, 2003; Provider and supplier notification: Immediate upon publication **Discard Date:** January 1, 2004 Post-Implementation Contact: Regional Office	**Effective Date:** January 1, 2003; **Funding:** Within current operating budget **Pre-Implementation Contact:** Elizabeth Carmody (410) 786-7533, ecarmody@cms.hhs.gov and Cindy Murphy, (410) 786-5733, cmurphy1@cms.hhs.gov

ATTACHMENT

SNF Consolidated Billing HCPCS Coding List

The following is a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing (CB). **New codes listed subsequent to prior publications appear in bold in HCPCS code charts. Boldface is also used outside of the code charts in cases as noted when type of bill (i.e., bill type) or revenue codes, rather than HCPCS codes, are used to perform editing. Bolding is also used to highlight titles, captions and other billing information for SNFs.** Codes from previous lists not appearing here have been deleted. Since there is a 3-month grace period in which deleted HCPCS codes are still allowed to process, codes remain listed here if the 3-month grace period overlaps with this update.

MAJOR CATEGORY I

Exclusion of Services Beyond the Scope of a SNF

The 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 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 fro SNF CB, with exceptions as listed below.

- Note that anesthesia, drugs incident to radiology and supplies (**revenues codes 037x, 0255, 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 in the table below) 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).

A. Computerized Axial Tomography (CT) Scans

70450	70460	70470	70480	70481	70482	70486	70487	70488
70490	70491	70492	70496	70498	71250	71260	71270	71275
72125	72126	72127	72128	72129	72130	72131	72132	72133
72191	72192	72193	72194	73200	73201	73202	73206	73700
73701	73702	73706	74150	74160	74170	74175	75635	76355
76360	76362	76370	76375	76380	**76497**	G0131	G0132	

B. Cardiac Catheterization

33967	**33968**							
93501	93503	93505	93508	93510	93511	93514	93524	93526
93527	93528	93529	93530	93531	93532	93533	93539	93540
93541	93542	93543	93544	93545	93555	93556	93561	93562
93571	93572							

C. Magnetic Resonance Imaging (MRIs)

70336	70540	70542	70543	70544	70545	70546	70547	70548
70549	70551	70552	70553	71550	71551	71552	71555	72141
72142	72146	72147	72148	72149	72156	72157	72158	72195
72196	72197	73218	73219	73220	73221	73222	73223	73718
73719	73720	73721	73722	73723	73725	74181	74182	74183
74185	75552	75553	75554	75555	***75556**	76093	76094	76390
76394	76400	**76498**						
C8900	**C8901**	**C8902**	**C8903**	**C8904**	**C8905**	**C8906**	**C8907**	**C8908**
C8909	**C8910**	**C8911**	**C8912**	**C8913**	**C8914**			

* This service is not covered by Medicare

D. Radiation Therapy

77261	77262	77263	77280	77285	77290	77295	77299	77300
77301	77305	77310	77315	77321	77326	77327	77328	77331
77332	77333	77334	77336	77370	77399	77401	77402	77403
77404	77406	77407	77408	77409	77411	77412	77413	77414
77416	77417	77418	77427	77431	77432	77470	77499	77520
77522	77523	77525	77600	77605	77610	77615	77620	77750
77761	77762	77763	77776	77777	77778	77781	77782	77783
77784	77789	77790	77799	G0173	G0242	G0243		

E. Angiography, Lymphatic, Venous and Related Procedures

75600	75605	75625	75630	75635	75650	75658	75660	75662
75665	75671	75676	75680	75685	75705	75710	75716	75722
75724	75726	75731	75733	75736	75741	75743	75746	75756
75774	75790	75801*	75803*	75805*	75807*	75809*	75810*	75820*
75822*	75825*	75827*	75831*	75833*	75840*	75842*	75860*	75870*
75872*	75880*	75885*	75887*	75889*	75891*	75893*	75894	75896
75898	75900	75940	75960	75961	75962	75964	75966	75968
75970	75978	75980	75982	75992	75993	75994	75995	75996

* Lymphatic procedures are Codes 75801 through 75807, and venous procedures are Codes 75809 through 75893.

F. Outpatient Surgery and Related Procedures - INCLUSION

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 (*).*

- Note that anesthesia, drugs, supplies and lab services (**revenues codes 037x, 0250, 027x, 062x and 030x**) will be bypassed by enforcement edits when billed with outpatient surgeries excluded from SNF CB.

THESE HCPCS CODES MAY NOT BE PAID SEPARATELY FROM SNF PPS

10040	10060	10080	10120	11040	11041	11042	11043	11044
11055	11056	11057	11200	11300	11305	11400	11719	11720

11721	11740	11900	11901	11920	11921	11922	11950	11951
11952	11954	11975	11976	11977	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15810	15811	16000
16020	17000	17003	17004	17110	17111	17250	17340	17360
17380	17999	20000	**20526**	20551	20552	20553	20974	21084
21085	21497	26010	29058	29065	29075	29085	29086	29105
29125	29126	29130	29131	29200	*29220	*29240	*29260	*29280
29345	29355	29358	29365	29405	29425	29435	29440	29445
29450	29505	29515	*29540	*29550	*29580	*29590	29700	29705
29710	29715	29720	29730	29740	29750	29799	30300	30901
31720	31725	31730	36000	36002	36140	36400	36405	36406
36430	36468	36469	36470	36471	††36489	††36491	36600	36620
36680	38220	38221	44500	51772	51784	51785	51792	51795
51797	53601	53660	53661	53670	53675	54150	54235	54240
54250	55870	57160	57170	58301	58321	85233	59020	59025
59425	59426	59430	62367	62368	*64550	65205	69000	69200
69210	95970	95971	95972	95973	95974	95975	99183	G0167
G0168								

* For Part B, these codes are defined as therapy when rendered by a therapist, but when they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants), they are defined as surgery and may be billed by the rendering provider. See V. A. for therapy inclusions.
†† These HCPCS codes are included in Part A payment when performed alone or with other surgery, but are excluded if they occur with the same LIDOS as an excluded chemotherapy agent.

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).

H. Ambulance Trips - With Application to Major Category II

Note that ambulance trips associated with Major Category II A. services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.

A0425	A0426	A0427	A0428	A0429	A0430	A0431	A0432	**A0433**
A0434	**A0435**	A0436						
Q3019	**Q3020**							

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 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 drug EPO is used for ESRD beneficiaries. *Note that SNFs may not be paid for home dialysis supplies*.

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/Home Support Services
- 855 - Continuous Cycling Peritoneal Dialysis OPD/Home Support Services

HCPCS codes recognized for use with these revenue codes are:

Dialysis Supplies

A4651	**A4652**	**A4653**	**A4656**	**A4657**	A4660	A4663	**A4670***	A4680
A4690	**A4706**	**A4707**	**A4708**	**A4709**	A4712	A4714	**A4719**	**A4720**
A4721	**A4722**	**A4723**	**A4724**	**A4725**	**A4726**	A4730	**A4736**	**A4737**
A4740	A4750	A4755	A4760	A4765	**A4766**	A4770	A4771	A4772
A4773	A4774	**A4802**	A4860	A4870	**A4890**	**A4911**	**A4913****	A4918
A4927	**A4928**	**A4929**	**A4930**	**A4931**				

* Not covered by Medicare

** A4913 is a carrier priced code not billed by SNFs.

Dialysis Equipment

E1500	E1510	E1520	E1530	E1540	E1550	E1560	E1570	**E1575**
E1580	E1590	E1592	E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1632	E1635	E1636	**E1637**	**E1638****	**E1639**	**E1699***	

* E1699 is a carrier priced code not billed by SNFs.
** E1638 is being deleted starting 2003, so a 3-month grace period for billing will last into March 2003.

3. Coding Applicable to EPO Services

EPO is a drug Medicare approved for use by ESRD beneficiaries. Intermediary EPO 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)

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

J9000	J9001	**J9010**	J9015	J9017	J9020	J9040	J9045	J9050
J9060	J9062	J9065	J9070	J9080	J9090	J9091	J9093	J9094
J9095	J9096	J9097	J9100	J9110	J9120	J9130	J9140	J9150
J9151	J9160	J9170	J9180	J9181	J9182	J9185	J9200	J9201
J9206	J9208	J9211	J9230	J9245	J9265	J9266	J9268	J9270
J9280	J9290	J9291	J9293	J9300	J9310	J9320	J9340	J9350
J9355	J9357	J9360	J9370	J9375	J9380	J9390	J9600	

B. Chemotherapy Administration

These codes 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.

3620	36261	36262	36489	36491	36530	36531	36532	36533
36534	36535	36640	36823	96405	96406	96408	96410	96412
96414	96420	96422	96423	96425	96440	96445	96450	96520
96530	96542	Q0083	Q0084	Q0085				

C. Radioisotopes

79030	79035	79100	79200	79300	79400	79420	79440	

D. Customized Prosthetic Devices

K0556	**K0557**	**K0558**	**K0559**					
L5050	L5060	L5100	L5105	L5150	L5160	L5200	L5210	L5220
L5230	L5250	L5270	L5280	L5301	L5311	L5321	L5331	L5341
L5500	L5505	L5510	L5520	L5530	L5535	L5540	L5560	L5570
L5580	L5585	L5590	L5595	L5600	L5610	L5611	L5613	L5614
L5616	L5617	L5618	L5620	L5622	L5627	L5626	L5628	L5629
L5630	L5631	L5632	L5634	L5636	L5637	L5638	L5639	L5640
L5642	L5643	L5644	L5645	L5646	L5647	L5648	L5649	L5650
L5651	L5652	L5653	L5654	L5655	L5656	L5658	L5660	L5661
L5662	L5663	L5664	L5665	L5666	L5668	L5670	L5671	L5672
L5674	L5675	L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697	L5698	L5699
L5700	L5701	L5702	L5704	L5705	L5706	L5707	L5710	L5711
L5712	L5714	L5716	L5718	L5722	L5724	L5726	L5728	L5780
L5782	L5785	L5790	L5795	L5810	L5811	L5812	L5814	L5816
L5818	L5822	L5824	L5826	L5828	L5830	L5840	L5845	L5846
L5847	**L5848**	L5850	L5855	L5910	L5920	L5925	L5930	L5940
L5950	L5960	L5962	L5964	L5966	L5968	L5970	L5972	L5974
L5975	L5976	L5978	L5979	L5980	L5981	L5982	L5984	L5985

L5986	L5988	L5989	L5990	**L5995**	L6050	L6055	L6100	L6110
L6120	L6130	L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570	L6580	L6582
L6584	L6586	L6588	L6590	L6600	L6605	L6610	L6615	L6616
L6620	L6623	L6625	L6628	L6629	L6630	L6632	L6635	L6637
L6638	L6640	L6641	L6642	L6645	**L6646**	**L6647**	**L6648**	L6650
L6655	L6660	L6665	L6670	L6672	L6675	L6676	L6680	L6682
L6684	L6686	L6687	L6688	L6689	L6690	L6691	L6692	L6693
L6700	L6705	L6710	L6715	L6720	L6725	L6730	L6735	L6740
L6745	L6750	L6755	L6765	L6770	L6775	L6780	L6790	L6795
L6800	L6805	L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865	L6867	L6868
L6870	L6872	L6873	L6875	L6880	L6881	L6882	L6920	L6925
L6930	L6935	L6940	L6945	L6950	L6955	L6960	L6965	L6970
L6975	L7010	L7015	L7020	L7025	L7030	L7035	L7040	L7045
L7170	L7180	L7185	L7186	L7190	L7191	L7260	L7261	L7266
L7272	L7274	L7362	L7364	L7366				

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.

Formerly, *bone mass measurement* (screening) was listed as a preventive service excluded from SNF consolidated billing. This was incorrect. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.

A. Mammography

Mammography screening codes are billed with revenue code 0403 and no other services on the bill.

G0202	G0203	**76090**	**76091**	76092				

B. Vaccines (Pneumococcal, Flu or Hepatitis B)

Pneumococcal, flu or hepatitis B vaccines are billed with **revenue code 0636**.

90657	90658	90659	90723	90732	90740*	90743*	90744*	90746*
90747*	90748**	**Q3021**	**Q3022**	**Q3023**				

* Not covered by Medicare
** Medicare pays only when this procedure is medically necessary.

C. Vaccine Administration

Vaccine administration codes are billed with **revenue code 0771**.

G0008	G0009	G0010						

D. Screening Pap Smear and Pelvic Exams

Screening Pap smear and pelvic examination codes are billed with diagnosis codes V76.2 or V15.89.

G0101	G0123	G0143	G0144	G0145	G0147	G0148	P3000	Q0091

E. Colorectal Screening Services

Colorectal screening services are billed with any of the following diagnosis codes: 'V10.05', 'V10.06', '555.0', '555.2', '555.9', '556.0', '556.1', '556.2', '556.3', '556.8', '556.9', '558.2', '558.9'.

G0104	G0106	G0107	G0120	***G0122**				

F. Prostate Cancer Screening

G0102, prostate cancer screening digital rectal examination, is billed with **revenue code 0770**. **G0103**, prostate cancer screening specific antigen testing, is billed with **revenue code 030x**.

G0102	G0103							

G. Glaucoma Screening

G0117	G0118							

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.**

• The following debridement HCPCS codes were incorrectly shown as being billable by a therapist. Effective July 1, 2002, CWF removed the HCPCS codes 11040, 11041, 11042, 11043, and 11044 from the therapy code files used in CWF editing. These HCPCS codes are still listed as included in SNF PPS and CB as ambulatory surgery. There is no distinct technical portion for these HCPCS codes that should have been billed to the FI. Physicians or physician equivalents may continue to bill Medicare carriers for their professional services for these codes:

11040, 11041, 11042, 11043 and 11044.

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

0029T	*29105	*29125	*29126	*29130	*29131	*29220	*29240	*29260
*29280	29520	29530	*29540	*29550	*29580	*29590	*64550	
90901	90911	92506	92507	92508	92510	†92525	92526	**92601**
92602	**92603**	**92604**	**92605**	**92606**	**92607**	**92608**	**92609**	**92610**
92611	**92612**	**92613**	**92614**	**92615**	**92616**	95831	95832	95833
95834	95851	95852	96000	96001	96002	96003	96105	96110
96111	96115	97001	97002	97003	**97004**	**†97005**	**†97006**	**97010
97012	97014	97016	97018	97020	97022	97024	97026	97028
97034	97035	97036	97039	97110	97112	97113	97116	97124
97032	97033	97139	97140	97150	97504	97520	97530	97532
97533	97535	97537	97542	97545	97546	97601	=97602	97703
97750	97799							
†G0192	G0193	G0194	G0195	G0196	G0197	G0198	G0199	G0200
G0201	**G0279**	**G0280**	**G0281**	**♦G0282**	**G0283**	**♦G0295**		
V5362	V5363	V5364						

* For Part B, these codes are defined as therapy when rendered by a therapist (revenue codes '042X' (physical therapy), '043X' (occupational therapy) and, '044X' (speech therapy)). When they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants) (any other revenue codes), they are defined as surgery and may be billed by the rendering provider. See I.F., Outpatient Surgery, for other such codes.

** Payment for code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.

= 97602 is bundled with other rehabilitation services. It may be bundled with any therapy code.

† Procedures not covered by Medicare.

♦ G0282 and G0295 are being deleted 2003, a 3-month grace period for billing will last into March 2003.

README: DESCRIPTION OF FILE AND DATA ELEMENTS
CMS SNF HCPCS HELP FILE
UPDATED OCTOBER 29, 2002

A - Purpose

The file has two purposes.
1 - to define by HCPCS code whether the service is considered included in the Part A SNF PPS rate, and
2- for outpatients and for residents for whom Part A payments cannot be made (e.g., benefits exhausted, non covered level of care, no Part A entitlement), to describe the following items related to the Part B billing for the service.

- whether the SNF can bill the service,
- whether the HCPCS code for the service requires a modifier, and
- how the service is priced and paid by the intermediary.

B - What the File Contains

The following data elements are shown in response to the query, and also contained in the Excel files:

- HCPCS Code
- HCPCS Description
- Whether Service Included in Part A PPS Rate
- Part B Coverage Status Manual Reference
- Part B PC/TC Indicator
- Part B Price Method
- Part B Price Code
- Comments

HCPCS Code - The HCPCS numeric or alphanumeric code.
HCPCS Description - The approved short description for numeric codes or the long description for alpha-numeric codes.
Included in Part A PPS Bill - A YES indicates that the service is included in the PPS rate. A NO indicates that it is not. A COM means special rules apply that are described in the **Comments** field. Services provided to a Part A resident are included in the SNF PPS rate. They may not be billed separately by the SNF or by any other provider or supplier. This would be duplicate billing.
The remainder of the table data relates to Part B payment.
Some services excluded from the Part A PPS rate may be separately billed by the SNF or by another entity that provides the service. Also, if the service is not paid under PPS, because Part A payment could not be made (e.g., the beneficiary not entitled to A, benefits exhausted, non covered level of care, etc.;) Part B payment may be possible.
Part B Coverage Status Manual Reference - Shows where the service is discussed in CMS manuals.
Part B PC/TC Indicator - This is an indicator that CMS uses to inform carriers and intermediaries about the characteristics of the services described by the code with respect to whether the service is a physician component or a technical component, or whether a modifier is required on the code to describe the component.
A number of HCPCS codes may include a service such as a test and related equipment that is considered a non physician service or technical component, and may also include a physician

service such as interpretation of the test. In general, claims for physician services are processed by the carrier, and technical component is processed by the intermediary. Other HCPCS codes are for physician component or for the technical component.
Following are the PC/TC codes that CMS uses and the related processing guidelines for intermediaries.
Generally, SNFs may bill only for covered SNF services with TC/PC codes with indicators of 3,5,7,9 and may bill for TC/PC indicator 1 with modifier TC. However, explicit instructions may state otherwise, e.g., the SNF must bill all rehab codes and some surgery codes, and some codes are defined as rehab that the SNF must bill, and as surgery codes the SNF is not required to bill depending upon related services provided.

Code Values for PC/TC Indicator PT B

0 - Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical component. They are not billed with a TC or 26 (PC) modifier. Intermediaries reject the service unless an exception is stated in the comments field (e.g., rehab) and notify the SNF to request the physician to bill the carrier. Physicians submit these services to the carrier for processing and reimbursement.

1 - Diagnostic Tests or Radiology Services: An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. A SNF can bill only for the TC component and must use the TC modifier (e.g., G0030TC). If a global code is submitted, e.g., G0030 with no modifier, FIs reject the service and notify the SNF to resubmit only the TC. If modifier 26 (PC) is submitted, FIs reject the service and notify the SNF that the professional component must be billed by the physician to the carrier.

2 - Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC. Intermediaries reject these services and notify the SNF that the service must be billed to the carrier.

3 - Technical Component Only Codes: Codes with an indicator of 3 signify services that have only a TC. Intermediaries pay these without a modifier, unless specifically noted otherwise in the help file.

4 - Global Test Only Codes: Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service. FIs reject the service and notify the SNF to resubmit the service using the code that represents the TC only.

5 - Incident To Codes: These codes normally are not considered physician services in the SNF setting. The SNF may bill these codes to the intermediary without a TC modifier (except for the codes identified as not billable by SNFs).

6 - Laboratory Physician Interpretation Codes: These codes are for physician services to interpret lab tests. Intermediaries do not pay for these services. They reject the service and notify the SNF that the services must be billed to the carrier. Considered a billable physician service and may be paid by the carrier to the physician. There are none of these codes shown on the help file.

7 - Therapy Services: These services are only billable by the SNF to the intermediary. The TC modifier is not needed. Note that other modifiers may be required under the therapy fee schedule. These are not described here. Note that some codes are not considered to be rehabilitation (therapy) services when delivered by a clinical psychologist, psychiatrist, or clinical social worker, for treatment of a psychiatric condition. These are identified.

8 - Physician Interpretation Codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 85060, and P3001-26. A TC indicator is not applicable. Intermediaries do not pay for these services. They reject the service and notify the SNF that the services must be billed to the carrier. Carriers reimburse the physician for these codes when submitted.
9 - Concept of a Professional/Technical Component Does Not Apply: An indicator of 9 signifies a code that is not considered to be a physician service. See the comments column to determine who may bill.
Part B Price Method - This column describes the Part B price method. Possibilities are fee schedule, reasonable cost, a payment rate, a payment limit, or price established by an individual carrier (including reasonable charge and individual consideration). Charges for reasonable cost items should be listed as Medicare charges on your cost report. Other items are considered final payment and are not listed as Medicare charges. Note that this column applies to SNFs only.
Part B Price Code (alphanumeric file only) - the pricing code from the CMS system that identifies pricing methodology for alphanumeric codes -
00 - Service not separately priced by Part B (e.g., services not covered, bundled, used by Part A only, etc.)
Physician fee schedule and non-physician practitioners
11 - Price established using national relative value units (REV's)
12 - Price established using national anesthesia base units
13 - Price established by Carriers (e.g., not otherwise classified, individual determination, Carrier discretion
Clinical Lab Fee Schedule:
21 - Price subject to national limitation amount
22 - Price established by Carriers (e.g., gap-fills, Carrier established panels)
31 - Frequently serviced Durable Medical Equipment (DME) (Price subject to floors and ceilings)
32 - Inexpensive and routinely purchased DME (Price subject to floors and ceilings)
33 - Oxygen and oxygen equipment (Price subject to floors and ceilings)
34 - DME supplies (Price subject to floors and ceilings)
35 - Surgical dressings (Price subject to floors and ceilings)
36 - Capped rental DME (Price subject to floors and ceilings)
37 - Ostomy, tracheostomy, and urological supplies (Price subject to floors and ceilings)
38 - Orthotics, prosthetics, prosthetic devices and vision services (Price subject to floors and ceilings)
45 - Customized DME items
46 - Carrier priced (e.g., not otherwise classified, individual determination, Carrier discretion, gap-filled amounts)
Other
51 - Drugs
52 - Reasonable charge (also used for reasonable cost, and for rate for ambulance services before implementation of the ambulance fee schedule
54 - Vaccinations
57 - Other Carrier priced
99 - Value not established

Comments
Comments include additional information, such as the effective date for the code or policy, and any restrictions on what provider/supplier types might be allowed to bill for the HCPCS code.
Updates from the Last Version
This version of the Help File has been updated so that listings for HCPCS codes in the SNF consolidated billing PM update effective January 03 is PM are consistent.

Additionally, the following information is provided on changes from the previous version of the Help File for codes not appearing in SNF consolidated billing PM:

- HCPCS codes: 69090, 72159, 73225 are not covered by Medicare. Previously they were shown as "Hospital or CAH must bill."

- The previous incorrect description was for a service that could be billed under arrangement. Intermediaries are to deny HCPCS code G0179.

- Ambulance codes also listed in the PM are paid under the ambulance fee schedule. Ambulance Code A0999 cannot be billed to FIs and therefore is only listed in the Help File. CMS added this code to those not separately payable by the FI.

- HCPCS code G0105 was shown as excluded from SNF CB and as colorectal screening services that must be billed by the SNF. This code can only be paid to physicians, and are shown in the Help File as "Physician billing to carrier."

- The description of HCPCS code G0179 is corrected and as a result the code has become classified as "Physician billing to carrier." The previous incorrect description was for a service that could be billed under arrangement. Intermediaries are to deny HCPCS code G0179.

- Procedures previously listed as not payable to SNFs, which failed to acknowledge that SNFs, though they may not perform these procedures, may bill such procedures under an arrangement for beneficiaries in a Part B stay, have been corrected in the "Comments" column of the File. If any other comments need correction on this point, they will be addressed in transmittals on update versions of the Help File.

- END -