CHAPTER 1: HISTORY AND PART A REQUIREMENTS

CONSOLIDATED BILLING REQUIREMENTS

BBA Regulations Affecting Part A and Part B Billing

Section 4432 (b) of the Balanced Budget Act (BBA) of 1997 contains the requirement that SNFs must submit all Medicare claims for all the services provided to their residents, with the exception of statutory exclusions, beginning July 1, 1998.

Who is Governed by Consolidated Billing

Who is governed by consolidated billing?

Consolidated billing requirements govern all Medicare fee-for-service beneficiaries residing in a participating SNF or in the nonparticipating remainder of a nursing home (NH) that also includes a participating distinct part SNF.

- Consolidated billing began for the Part A resident at the beginning of the SNF's new cost report year on or after 7/1/98.

- **Part B consolidated billing, delayed repeatedly since July 1998, has been rescinded per BIPA (Benefits Improvement and Protection Act) of 2000 except for therapy services.**
  - For residents in a non-Part A covered stay, only therapy services are subject to consolidated billing for services with a date of service on or after April 1, 2001.

Services Not Included in the Extended Care Benefit

Services not included in the extended care benefit for Part A residents of a SNF are excluded from the consolidating billing requirements.

- A Flu shot, as a preventative service, is an example of Part B services not bound by consolidated billing regulations.

Inpatient Defined

For the purposes of consolidated billing, a Medicare beneficiary who resides in a SNF is considered to be an inpatient of a SNF until which time the resident changes his status by the following action:

Who is an Inpatient?

- **Consolidated billing rules**
- **Status codes of residents leaving the SNF and the how it affects a resident's "inpatient" status**

- discharged to home, self care
  (status **01** in FL 22)
- discharged/transferred to another short-term general hospital for inpatient care
  (status **02** in FL 22)
- discharged/transferred to SNF
  (status **03** in FL 22)
  (status **61** if hospital swing bed)
  (status **04** if to a non-certified SNF)
- discharged/transferred to another type of institution (including distinct parts
  (status **05** in FL 22)
- discharged/transferred to home under HHA care
  (status **06** in FL 22)
- left against medical advice or discontinued care
  (status **07** in FL 22)
- admitted as an inpatient to this hospital (from observation bed following outpatient surgery)
  (status **09** in FL 22)
- expired (or did not recover-Christian Science patient)
  (status **20** in FL 22)
- discharged to hospice - home
  (status **50** in FL 22)
- discharged to hospice - medical facility
  (status **51** in FL 22)

Consolidated billing requires that charges for outside services must be charged back to the SNF if the beneficiary is covered under Medicare Part A and the SNF is receiving SNF PPS payment for that day.

- **Services provided outside the SNF on date of beneficiary's discharge or on LOA days do not have to be charged back to the SNF for payment because the resident is not considered to be an "inpatient" of the SNF on those days and the SNF is not receiving Part A reimbursement.**

- Effective 4/1/01 all Medicare Part B beneficiaries living in a certified SNF must be considered "inpatient" regardless of their placement in a certified or non-certified bed

COMPONENTS OF CONSOLIDATED BILLING

Services Billed on Part A claim (21X) to the Intermediary Include:

Requirements for Part A claims

- All services allowed under Part A stay per Section 230 of the SNF manual (HCFA Pub-12) must be reported on a UB-92 using a line item ancillary revenue code and total charges for that service.

- Services required to be included on the Part A claim are those rendered within the facility (either directly or under arrangement) and those rendered "off-site" (with the exception of those services excluded by BBA).

Services Covered by Medicare Part B for SNF Residents (not covered by Part A) May be Billed to Either the Intermediary or Carrier Depending on Provider Rendering the Service

Services billed on a Part B (22X) claim

- Per Section 260 of the SNF Manual (HCFA PUB-12) and the requirements of BBA, the following services are billable on a Part B claim (22X):

  - Diagnostic X-ray tests
  - Diagnostic laboratory tests
  - X-rays, radiological services, radium and radioactive isotope therapy

- Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations
- Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes (including adjustment, repairs and replacements)
- Vaccinations or inoculations specifically for flu, PPV and hepatitis B
- Approved oral cancer and anti-emetic drugs
- Hemophilia clotting factor
- Ambulance
- Physical, occupational and speech therapy

Services Billed on Part B Claim will be Subject to Consolidated Billing Regulations for *Therapy Services (only)* effective 4/1/01

Effective January 1, 1999, ALL therapy services for a Part B SNF resident must be sent to the Intermediary on a 22X claim.

Services Exempt from Consolidated Billing

HCFA has provided a list of those services not normally within the SNF purview to provide and therefore not bound by consolidated billing rules.

Excluded Services

Exclusions originally listed in Interim Final Rule (IFR):

Excluded Services Per IFR

- Physicians (professional component of physician services)
- physician assistants working under a physician's supervision
- nurse practitioners and clinical nurse specialists working in collaboration with a physician
- certified nurse-midwives
- qualified psychologists

- certified registered nurse anesthetists
- home dialysis supplies and equipment, self-care home dialysis support services and institutional dialysis services and supplies
- Erythropoietin (EPO) for certain dialysis patients
- hospice care related to a beneficiary's terminal condition
- an ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge
- **for 1998 only** - transportation costs of EKG equipment for electrocardiogram test services (HCPC R7006) rendered during 1998

Exclusions From Federal Register/Vol. 63 No. 91 Effective July 1, 1998

Additional exclusions

- Cardiac catherization
- CT scans (provided by a hospital or CAH)
- MRI (provided by a hospital or CAH)
- Ambulatory surgery involving the use of an operating room
- Emergency room services billed to the Intermediary under revenue code 045X

Additional Exclusions per HCFA Transmittal No. A-98-37 Effective November 1, 1998

- Radiation therapy
- Angiography
- Lympathatic and venous procedure

Additional Exclusions per BBRA (11/99) Effective 4/01/00

- Chemotherapy items (some chemotherapy is included in SNF PPS)

- Chemotherapy administration services
- Radioisotope services
- Customized prosthetic devices
- Ambulance transport for renal dialysis services

Bundling of Charges

The IFR and FR both refer to the "bundling of charges." This means that under consolidated billing provisions, **the costs for rendering services (other than those excluded) to a SNF Part A resident must be charged back to the SNF for payment**. Because HCFA has determined that the SNF reimbursement rates contain payment for all of these services, separate claims may not be submitted to Medicare.

SPECIAL CIRCUMSTANCES REQUIRING APPLICATION OF CONSOLIDATED BILLING PRINCIPLES

Leave of Absence (LOA)

Medicare beneficiaries absent from the SNF at midnight "census taking" time must be considered to be on a leave of absence.

A resident on a LOA at midnight cannot use a Part A benefit day.

Leave of absence

- Benefit days are not applied, nor is Part A reimbursement made, if the beneficiary is absent at midnight.
- Consolidated billing rules do not apply if the SNF is not receiving Part A PPS reimbursement

A SNF Part A resident who is absent for more than 24 hours receiving outpatient services is no longer considered an "inpatient" for consolidated billing purposes.

- During medical absences of more than 24 hours, the charges for services rendered **may be billed**

directly to Medicare by the entity performing the service.

- Absences of greater than 24 hours (on a medical leave) require SNFs to consider the patient "discharged," **except when on social leave**

Services and Treatments Provided "Under Arrangement"

Consolidated billing requires that services provided by individuals or companies other than the employees of the SNF must be billed to the FI on the HCFA-1450 for Medicare beneficiaries covered under Part A (and Part B beneficiaries receiving covered therapy services). The SNF must do the billing.

– The providers must look to the SNF for reimbursement, not the FI.

Items Provided by Outside Suppliers/Contracted Staff to SNF Part A Residents

Changes to billing for "under arrangement" services

- **DMERC billing**
- **Carrier billing**

- orthotics/prosthetics
- ostomy/colostomy supplies
- sterile dressings/surgical dressings and supplies
- enteral/parenteral nutrition and supplies
- independent laboratory services
- portable X-ray
- physical therapy, occupational therapy and speech therapy

Services Provided to SNF Residents Outside the SNF Facility

In addition to services rendered to a patient within the SNF, certain other services provided to a Medicare beneficiary outside of the facility must be charged back to the SNF by the outside provider:

Billing for services rendered out of the SNF

- all services, unless excluded by statute, which must be bundled back to the SNF for payment and for reporting to the FI on a HCFA 1450 (UB-92).

- ambulance services for medically necessary transport (as defined by carrier criteria) of SNF inpatients to outside services unless excluded by statute.

- The SNF must do the billing to the FI.

- The provider must look to the SNF (not the FI) for payment.

SNFs are free to choose vendors and providers for contractual agreements as long as those agreements do not violate the existing anti-kickback statutes.

Plan of Care

Plan of care

The FR makes the following two clarifications regarding plan of care and consolidated billing provisions.

- If a service is excluded by statute (e.g., CT scan), that service is always excluded from consolidated billing, even if that service is a part of the resident's plan of care.

- Outside services are not automatically excluded from consolidated billing because they are not in a **specific patient's plan of care,** but must be defined on the broader level of services beyond the purview of the SNF to provide **in general .**

Enteral and Parenteral Nutrition

Medicare Part A

Medicare Part A :

- Parenteral nutrition is considered a drug and is billed under revenue code 0260 (IV drugs), and supplies to administer the nutrition are billed under revenue code 0270 (medical/surgical supplies) or revenue code 0264 (IV therapy supplies).

- Enteral nutrition is considered "routine" under Medicare Part A and is not billable to the FI or to the DMERC by the SNF.

Medicare Part B:

Medicare Part B

- Parenteral and enteral nutrition formula and supplies may be billed to the DMERC by the SNF if the SNF has a DMERC provider number, or

- May be billed by the supplier directly to the DMERC if the SNF wishes to have the vendor do the billing on behalf of the Part B beneficiary.

Emergency Room Services

Emergency room services are exempt from consolidated billing provisions if:

- Treatment is for a "life or death" situation, or one involving "serious impairment of health."

Services in the emergency room

Any other routine services provided to the patient while they are in the emergency room **must** be charged back to the SNF.

Use of the Operating Room

- Ambulatory surgery services must be rendered in an operating room in order to be exempt from consolidated billing provisions.

Services in an operating room

- With respect to **PEG tubes procedures**, HCFA considers the use of the GI suite or endoscopy suite as equivalent to the use of the operating room for the purpose of this exclusion.

Services Furnished "Incident To" A Professional Service

The professional component of physicians and other professionals (see BBA list of those medical personnel excluded from bundling) are billed directly to the Part B carrier.

Services "incident to" a professional service

- Services "incident to" the professional service must be billed on the SNF Part A claim to the FI.

  Examples of services "incident to" are surgical dressings when ordered by the physician.

- The technical component of a visit with a professional is **not** exempt from consolidated billing and must be bundled back to the SNF.
  - The physician or other professional must look to the SNF (not the FI) for payment of the technical component.

Dialysis Services for Part A Beneficiaries

Dialysis services **are excluded** from the consolidated billing provision if:

- Services are rendered to the beneficiary **on the site** of a Medicare certified ESRD facility or a hospital certified by Medicare to render outpatient dialysis.
- Supplies and equipment are provided to a beneficiary in a SNF who has been trained perform **self dialysis** (home dialysis).

Dialysis in a SNF

Dialysis services **are not excluded** from the consolidated billing provision if:

- Services are provided to the beneficiary **at the SNF** by staff from an ESRD facility or hospital under arrangement.
  - Services provided on the site of the SNF are included in the daily SNF PPS rate.
  - The SNF must pay the ESRD facility or hospital and report these charges on the SNF claim to the FI.

Home Dialysis Beneficiaries

The supplies and equipment for home dialysis beneficiaries residing in a SNF are excluded from consolidated billing provisions.

- Equipment and supplies may not be shared with other residents.
- Nursing staff assistance to perform home dialysis in the SNF may not be billed to Medicare – this service is considered “routine.”

Freestanding ESRD facilities and hospitals may apply to the state and HCFA to establish separate certification of an ESRD unit within a SNF.

Billing of ancillaries

Lab and X-ray Services

Lab and X-ray charges should be billed to the SNF by entity performing the service for Part A beneficiaries.

- If a facility has its own lab and radiology units, the claims are billed directly to the FI by the SNF.
- If services are performed by portable X-ray companies, independent labs, or hospitals, the claims are sent by these providers to the SNF for payment. The SNF must report these services on its Part A claim.

Orthotics and Prosthetics

Orthotics and prosthetics supplies and equipment are governed by the consolidated billing provisions of BBA.

- Supplies and equipment received by the beneficiary during a Part A stay are the financial responsibility of the SNF.
- The supplier must look to the SNF for payment, not the DMERC.

Drugs and Biologicals

Drugs and biologicals are a covered service under Part A in a SNF and are included in the PPS payment.

- Drugs obtained from an outside source are the financial responsibility of the SNF.
  - The supplier of the drug must look to the SNF (not the FI or Carrier) for payment.
- A beneficiary's supplemental insurance (RX policy) should not be used when obtaining prescriptions until his/her Part A stay ends.

Consolidated Billing Special Rules for Ambulance Transport of SNF Residents

Medicare payment can be made for medically necessary ambulance services for Part A and Part B beneficiaries. Consolidated billing provisions apply to SNF Part A beneficiaries.

Ambulance rules

SNFs are not responsible to make payment for Part A residents if an ambulance transports the beneficiary for:

- initial admission to a SNF
- final discharge to home
- hospital inpatient admission
- to and from an excluded service (except dialysis)

SNFs are responsible to make direct payment to an ambulance company whenever the SNF resident is transported by ambulance for:

- outpatient hospital services (except for exclusions)
- dialysis services (changed to an excluded service on 4/1/00)
- transfers to another SNF

NOTE: Medicare does not cover transportation via ambulette, wheelchair van, taxi or public transportation.

Consolidated Billing has been rescinded for SNF residents not covered in a Part A stay (except for therapy services). If a Part B resident requires ambulance transport, the ambulance company could bill the carrier (not the SNF) using their current billing practices.

SNF RESPONSIBILITY UNDER CONSOLIDATED BILLING

Non-Billing Responsibilities

In addition to preparing accurate, complete claims on a HCFA-1450 for processing by the FI, SNFs are required to monitor and regulate all patient care (including that rendered under arrangement).

The SNF must notify any outside provider if they are treating a SNF Part A beneficiary in order for that provider to correctly direct the charges back to the SNF for payment (unless the outside provider is providing an excluded service).

The SNF must pay for any service provided to a Part A beneficiary by an outside supplier unless that service is excluded from consolidated billing by statute.

Other Responsibilities

Non-Billing responsibilities

- Medical necessity of services
- Contracts with outside suppliers
- Certificates of Medical Necessity (CMN) from suppliers
- Payment to contractors for services rendered "under arrangement"

Billing Responsibilities on Part A Claims

Coding Part A claims per consolidated billing requirements

- Part A claims (21X bill type) **must** contain (in addition to the HIPPS code for the RUG III group in which the resident was classified) a line item listing (by revenue code) of **all services** rendered to the SNF INPATIENT resident during the dates of service on the claim.

- Adjustments must be sent to the FI if the SNF receives bills from outside suppliers or other providers of service whose charges should have been applied to an original SNF claim.

  - SNFs are responsible for billing the claim, and making payment to those contractors who have provided services to their Part A beneficiaries.

SNFs may contract with billing agencies for preparation and submission of claims to the FI, but may not "assign" to any other entity the legal responsibility for the claim or the right to receive Medicare payment.

Billing Responsibilities on Part B Claims Processed by FI

HCPCS coding requirements on Part B claims

- Part B claims (22X and 23X type of bill) will require HCPCS for all services which have an established fee schedule beginning 4/1/01.

PAYMENT UNDER CONSOLIDATED BILLING

Payment for ancillaries on a Part A claim are factored into the SNF PPS reimbursement

- Payment for ancillaries that are billed on a Part A claim are factored into the RUG III rate for each category in which the resident is classified.
  - Payment includes all reimbursement for services: routine, capital and ancillary.
  - Total payment will be a blend of the provider-specific rate and the national PPS rate.

Payment for ancillaries on a Part B claim :

- **Fee schedule**
- **Percentage of charges**

- Part B claims are paid according to fee schedule for those services in which HCFA has an established fee schedule in place and HCPCS will be required.
  - All others will be paid based on the percentage of charges rule until a fee schedule is developed for those services.

Financial Issues Regarding Payment for Part A Stays

Based on their participating agreements, SNFs may not charge the beneficiary the difference between the Medicare payment and the charges on the claim.

- Beneficiaries are financially responsible only for co-insurance amounts and services non-covered by Medicare for which a written notice of non-coverage has been issued.

SNFs will be in violation of their participation agreements if they discriminate against the Medicare beneficiary in their admission practices or in delivery of medically necessary services due to the level of payment.

CHAPTER 2: INTERMEDIARY REQUIREMENTS

CONSOLIDATED BILLING AND FEE SCHEDULE FOR SNF PER PM A-00-88

Billing and payment requirements for SNF Part B services were issued by HCFA in Program Memorandum A-00-88 for fiscal intermediaries. The requirements for consolidated billing were originally mandated in the Balanced Budget Act (BBA) of 1997. The Final Rule (FR) which was published on Aug. 28, 1999, clarified the coverage and billing criteria for SNF PPS.

Major Announcements in A-00-88

Consolidated billing for services rendered to a SNF resident not covered in a Part A stay has been **rescinded** (except therapies).

Policy Announcements per A-00-88

Consolidated billing remains in effect for services rendered to a Medicare beneficiary in a covered Part A stay.

- SNF PPS and consolidated billing requirements for Part A SNF residents applies to “fee for service” Medicare beneficiaries
- Managed care beneficiaries are exempt from the PPS and CB provisions
- Fee schedule payment is mandated for all Part B services that have a fee schedule developed
- CWF will install edits to prevent duplicate payment of services governed by consolidated billing for both SNF Part A and Part B beneficiaries
- Therapy services (PT, OT, SP) must be billed by the SNF regardless of beneficiary’s status as a Part A or Part B (non-covered under Part A) resident

Payment and Billing Changes Per A-00-88

A fee schedule methodology of payment will be required for all Part B services **effective April 1, 2001,** per Section 1888 (e) (9) of the Social Security Act (SSA) as modified by the BBA. When applying the fee schedule, payment will be lesser of the fee schedule amount or actual charges.

Services Covered by Fee Schedule

- Fee schedules are in place for the following services:
  - Therapy
  - Lab
  - Radiology and other diagnostic tests
  - Prosthetic and orthotic devices
  - Surgical dressings

- Fee schedules are either based on the locality of the provider or are statewide (or carrier-wide in states with multiple carriers), depending on the structure of the specific fee schedule

Part B Services NOT Covered by Fee Schedule

When a fee schedule has not yet been developed, the Part B services will be reimbursed on a reasonable cost basis.

Services NOT Covered by Fee Schedule

- No fee schedule exists at the current time for the following services:
  - Medical supplies
  - Therapeutic shoes
  - PEN codes – paid by fee at the DMERC
  - Blood products
  - Transfusion medicine
  - Drugs not billed under revenue code 0636

PUBLICATION OF FEE SCHEDULES

SNF fee schedule prices and related installation instructions will be provided to intermediaries through the Mainframe Telecommunication System.

Distinctions in SNF Fee Schedule

- SNFs bill only the **technical or facility component** for most services
  - except where they furnish the complete service or obtain the complete service under arrangement
  - professional component will continue to be billed to the Carrier

How SNF Fee Schedules Differ from Other Fee Schedule Payments

- Some services cannot be paid to SNFs
  - example – a SNF may not bill for physician services (except for those services furnished by an intern or a resident-in-training of a hospital with which the SNF has entered into a transfer agreement)
  –
- Certain services provided to SNF Part A beneficiaries, for which Part A benefits are payable, are not payable by anyone else
  - example – enteral feeding nutrients are covered under Part A for the SNF beneficiary and are NOT payable by the DMERC because these services are included in the PPS rate

- **Modifiers** will be needed to determine the correct payment **unless the related HCPCS code sufficiently defines the professional/ technical component**

- With two exceptions, SNFs may not obtain services of physicians under arrangement. The two exceptions are:
  - physical, occupational, and speech therapy services furnished to SNF residents (under consolidated billing, even when a physician performs any of these three services, they are

still considered “therapy” services rather than “physician” services and, as such, must be billed by the SNF)
- services furnished by an intern or a resident-in-training of a hospital with which the SNF has entered into a transfer agreement (see second bullet point above)

- Other services furnished by physicians are excluded from CB requirements per BBA of 1997

Use of Internet Fee Schedule File

Fee Schedule Via Mainframe Telecommunication System

HCFA will publish a public use file on the Internet for SNF inquiry or downloading and for use as reference material.

- SNFs will be expected to access this file for basic information about each HCPCS code
- Intermediaries may assist SNFs as appropriate
- Intermediaries and carriers may access this file to resolve inquiries
- File will contain the following data elements:
  - Fee schedule year
  - HCPCS codes
  - modifiers 26(PC/TC) if applicable
  - Narrative description of HCPCS code
  - Medicare coverage status reference
  - Pricing method
- Professional and technical (PC/TC) component indicator for the services
- Whether the code is billable by a SNF
- For codes billable by SNFs, the file will contain information regarding:
  - Whether the service is included or excluded from Part A PPS
  - Whether the service code consists of a professional, technical (facility) component or complete procedure

Determining Deductible and Coinsurance Responsibility

Applicable Coinsurance and Part B Deductible under Fee Schedule Reimbursement

- When payment is made for Part B SNF services (22X or 23X type of bill) using the fee schedule, the beneficiary coinsurance and deductible is based on the approved amount (Medicare payment amount).

- When the payment is made based on reasonable costs, coinsurance and deductibles continue to be calculated on the charges on the SNF claim.

- Coinsurance and deductibles do not apply to:
  - Clinical diagnostic tests
  - Special vaccines – PPV, Flu, and the administration of these vaccines
  - Screening mammography services

Special Rules Regarding SNF PPS Payment

Special Payment Rules Relating to Fee Schedule Payments for SNFs

SNFs provide services either directly or under arrangement. Part A SNF PPS payment includes rates which cover payment for ALL services **except those excluded from consolidated billing by statute**.

- Services excluded from the SNF PPS rate may not be billed by the SNF except for certain preventive and screening services

- When the Part A PPS payment is not applicable to a SNF resident, payment may be made for certain services under Part B

  - Fee schedule will apply if one exists

TYPES OF SERVICES BILLED UNDER SPECIAL PAYMENT RULES

The following services are billed under the Part B benefit for a SNF resident when Part A does not apply

Services Billed with Special Payment Rules

- **Set-up services in a SNF for portable X-ray equipment** when the SNF does not directly provide radiology services
  - Scope of the portable X-ray benefit is defined as: skeletal films, chest films, abdominal films
  - Set-up costs for portable X-ray equipment is billed using HCPCS Q0092
  - Set-up costs are **not** applicable for lab or EKG services
- **Specimen collection** in circumstances such as drawing **blood through venipuncture** (HCPCS G0001) or collecting a **urine sample by catheter** (HCPCS P9615)
  - Separate specimen collection is not paid for throat cultures, routine capillary puncture for clotting or bleeding time, nor for stool specimen
  - Costs for related supplies and items for specimen collection are NOT separately billable
  - Current lab fee schedule is used to pay the SNF if it draws the blood
  - Neither deductible nor co-insurance applies to specimen collection

Special Payment Rules for Travel Allowance

- **Travel allowance** for lab services may be paid to the SNF when the lab services are provided under arrangement with a supplier
  - HCFA rules for carriers will apply in determining travel allowance payments
  - When making trips to multiple clients, the supplier may charge only for the part of the travel allowed by Medicare
  - Travel allowance covers the cost of collecting the specimen and the technician's salary and travel cost
  - The supplier is expected to make all necessary calculations and submit the bill to the SNF
  - Travel allowance may be paid for actual miles traveled (HCPCS P9603) or prorated on a flat fee (HCPCS P9604)
  - There is a minimum of 75 cents per mile for HCPCS P9603 and it is to be used when the distance between the lab and the SNF is greater than 20 miles round trip. **Actual miles must be shown on the claim in the *units* field.**
    - Per mileage rate consists of the federal rate (34.5 cents per mile) and 44 cents to cover the technician's time and travel costs
    - Contractors have the option of establishing a higher payment per mile if local conditions warrant it

Special Payment Rules for Travel Allowance

- **Flat rate** has a minimum of $7.50 per mile (HCPCS P9604)

  - Applicable when the trip for specimen collection is less than 20 miles round trip from the supplier to the SNF
  - When the supplier services multiple patients, the supplier may bill only for the Medicare patients seen on the trip (see PM A-00-88 for examples)

- **Travel allowance for X-ray services** is payable only in connection with furnishing covered portable X-ray services under arrangement.

  - Intermediaries are required to set up edits to allow payment for the following codes (in conjunction with HCPCS 70000 – 799999):

  - Q0092 setup portable equipment
  - R0070 transportation when 1 patient is seen
  - R0075 transportation when more than 1 patient is seen
  - 99082 unusual travel

CONTRACTS BETWEEN LABS AND SNFS

SNF Contracts with Labs

HCFA has **no** requirement with respect to what the lab may bill the SNF or what the SNF may pay the lab. The HCFA instruction addresses what the SNF will be paid under Medicare for lab services. The SNFs are free to establish contracts with labs using free market principles as long as those contracts do not violate the anti-kickback statutes.

UB92 BILL TYPES, FREQUENCY OF BILLING AND LATE CHARGES

All Part B residents (not in a covered Part A stay) living in a SNF are to be considered **"inpatient"** of the SNF beginning April 1, 2001 regardless of their placement in a certified or non-certified bed.

Type of Bill for Part B SNF Services

- Part B claims for SNF inpatient residents are to be billed on claim type 22X
- Non-residents (beneficiaries living in the community) who come to the SNF for Part B services are to be billed on claim type 23X

UB92 Requirements for CB

Frequency of Billing

- Monthly billing requirements continue to apply

SNFs are expected to make a reasonable effort to collect all charges for services rendered during the month to their residents; however, billing of late received invoices is permissible.

- Adjustment bills are permitted to increase units for a previously reported HCPCS code
- Services for different HCPCS codes (not included on the original bill) may be billed as a new bill

(late charge claim), except for therapy services (revenue code 42X, 43X, 44X) which **must** be adjusted

- Late charge bills remain unacceptable for Part A claims

EXCLUSIONS

SNF PPS payment rates contain reimbursement for ALL services rendered to Part A SNF beneficiaries, except those services excluded by statute. The exclusions to Part A PPS reflect services not normally within the scope of the SNF to provide. In addition, HCFA has added additional exclusions for certain high cost services that were not factored into SNF PPS rates.

Types of Exclusions

(Exclusion List by HCPCS is in the addendum)

- **Physicians** and other medical staff permitted to bill the carrier for their professional fees (see exclusion list)
  - Professional (PC) and technical (TC) component indicators will be used in SNF billing (see addendum for chart)

Exclusions to Consolidated Billing

- **Dialysis Services** when rendered onsite of a certified ESRD facility or hospital certified to perform outpatient dialysis services

- **EPO** rendered in conjunction with certain dialysis patients

- **Hospice Services** related to a terminal illness

- **Certain ambulance trips** qualifying as “medically necessary”

  - To excluded services
  - Initial trip to the SNF and final discharge from the SNF
  - Trips to an inpatient admission

Services Excluded when rendered in a CAH or Acute Care Hospital

Exclusions when rendered by an Acute Care Hospital or CAH

- Cardiac catheterization
- CT scans
- MRIs
- Radiation therapy
- Ambulatory surgery involving the use of a hospital operating room (HCPCS 10040 – 69979) except for minor procedures
- The addendum exclusion list for surgical procedures are the EXCEPTIONS to the exclusions
- Emergency room services when rendered by an acute care hospital (revenue code 045X) or CAH
- Angiography Services
- Lymphatic and Venous Procedures

Exclusions when rendered by ANY Certified Medicare Provider

Services Excluded when rendered by ANY Certified Medicare Provider

- Chemotherapy
- Chemotherapy administration
- Radioisotope services
- Certain customized prosthetic devices
- Transportation of EKG equipment in 1998

EDITS FOR CONSOLIDATED BILLING

HCFA has directed CWF to install edits effective for claims with dates of services on or after April 1, 2001, to check for duplicate submission of claims. These edits will prevent payment to more than one provider for the same service rendered to a Part A or Part B (not in a covered Part A stay) SNF beneficiary. The CWF edits will

- Check for duplicate billing of a Part B service within the same dates or for overlapping dates of service of a SNF Part A claim

- Check for duplicate billing of a Part B service by both the SNF and a supplier

CWF Edits

Part A SNF PPS claims have payment priority over a Part B service (except exclusions and preventative care services).

- If a Part A SNF PPS claim is in history, CWF will reject the Part B claim back to the carrier or intermediary if the service overlaps or duplicates the dates of service of the Part A claim

- If a Part A claim is received with a paid Part B claim in history (with the same or overlapping dates of service), the Part A claim will be paid and the carrier or intermediary will be sent an unsolicited response to cancel the Part B claim
  - Contractors must establish procedures for recouping payment for claims which must be cancelled
  - Certain claims may have services that can be paid and others that must be rejected. Contractors are to return such claims to the provider for corrected billing

CHAPTER 3: CARRIER REQUIREMENTS

ENTRY OF THE SNF PROVIDER NUMBER

Per Section 4432 (b)(4) of the BBA, when physicians provide services to a beneficiary residing in a SNF, the physician must include the Medicare facility provider number of the SNF on the claim form or electronic record. The Medicare provider facility number of the SNF is the number assigned to the SNF by HCFA regional office when they are certified as a Medicare facility. This number is referred to as the OSCAR number.

Note: This requirement will be delayed until further notice.

USE OF THE PC/TC INDICATORS TO IDENTIFY PHYSICIAN'S SERVICES

Codes for diagnostic tests may include a technical portion (TC), which is the test itself and a professional component (PC) which is the physician's interpretation of the test. To identify the professional components of physician's services for SNF residents that are billable to the carrier, use the information in the Professional Component/Technical Component (PC/TC) Indicator field of the Medicare Physician Fee Schedule (MPFS) for payment. For Medicare purposes, physicians and physician's services are defined per Sections1861(q) and (r) of the Social Security Act.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, the physician will be paid for the professional component of physician services that have both technical and professional components or for those physician services that have only professional components. Technical components should be billed by the provider to the SNF for payment.

ANESTHESIA SERVICES

Anesthesia services have no separately identifiable technical component and should be billed to the carrier as a physician's professional services. CWF will bypass anesthesia codes and allow them to be paid by the carrier.

HCPCS codes for physical, occupational and speech language therapy services and audiologic function tests that are subject to consolidated billing

HCPCS CODES TO IDENTIFY PHYSICAL, OCCUPATIONAL AND SPEECH LANGUAGE THERAPY SERVICES AND AUDIOLOGIC FUNCTION TESTS THAT ARE SUBJECT TO CONSOLIDATED BILLING

Both Part A and Part B (not covered under Part A) stays are subject to Consolidated Billing for therapy services.

AMBULANCE CLAIMS

- Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, when beneficiaries are in a Part A covered SNF stay, the following information is applicable:

  When a medically necessary transport from one SNF to another SNF occurs (the beneficiary is charged from the first SNF and admitted to the second) the transport is included in the SNF PPS payment rate and is subject to consolidated billing.

  - The first SNF should include the ambulance charges on the Part A claim to the FI.

Services drugs and supplies that are excluded from consolidated billing.

SPECIFIC DRUGS, SERVICES AND SUPPLIES TO BE EXCLUDED FROM CONSOLIDATED BILLING

The services listed in **Appendix 1** are excluded from consolidated billing and should be billed to the carrier or DMERC as appropriate.

- Chemotherapy Drugs
- Chemotherapy Administration Services
- Radiosotope Services
- Cutomized Prosthetic Devices

EPO services are excluded from consolidated billing.

ERYTHROPOIETIN (EPO) SERVICES

EPO claims are not included in the SNF Part A PPS rates and are excluded from consolidated billing. They must be billed to the carrier or DMERC for payment. EPO services are identified by the following HCPCS codes:

- Q9920-Injection of EPO, per 1,000 units, at patient HCT of 20 or less;
- Q9921 through Q9939-Injection of EPO, per 1,000 units, at patient HCT of 21
- Q9940-Injection of EPO, per 1,000 units at patient HCT of 40 or above

Dialysis services are excluded from consolidated billing.

DIALYSIS

Home dialysis equipment, home dialysis support services institutional dialysis services and supplies are excluded from consolidated billing and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment. Claims for services for dialysis patients must have one of the following ICD-9-CM diagnosis codes:

403.01	403.11	403.91	404.02	404.12	404.92	584.5
584.6	584.7	584.8	584.9	585	586	788.5
958.5						

The Carrier PM (B-00-67) appears in the reference section of this manual.

ADDENDUM 1

HCPCS

Codes and Narratives

Billing for SNF Patients Receiving Services Excluded From the Consolidated Billing Provision of SNF PPS

Note: HCFA regulations require that certain Medicare participating facilities provide these services or they may not be considered an exclusion under consolidated billing provisions. Each category of HCPCS will state whether there is a limitation on type of provider who can render the service and still bill Medicare directly. If a type of service (HCPCS) is rendered to a SNF Medicare Part A beneficiary by a provider 'other than' the type specified by the regulation, the service no longer is considered an exclusion and only the SNF can be billed for the charges incurred.

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient **CT scans** are:

HCPCS	Explanation
70450	computerized axial tomography, head or brain; without contrast material
70460	computerized axial tomography, head or brain; with contrast material(s)
70470	computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70486	computerized axial tomography, maxillofacial area; without contrast material
70487	computerized axial tomography, maxillofacial area; with contrast material(s)
70488	computerized axial tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	computerized axial tomography, soft tissue neck; without contrast material
70491	computerized axial tomography, soft tissue neck; with contrast material(s)
70492	computerized axial tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
71250	computerized axial tomography, thorax; without contrast material
71260	computerized axial tomography, thorax; with contrast material(s)
71270	computerized axial tomography, thorax; without contrast material, followed by contrast material(s) and further sections
72125	computerized axial tomography, cervical spine; without contrast material
72126	computerized axial tomography, cervical spine; with contrast material
72127	computerized axial tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	computerized axial tomography, thoracic spine; without contrast material
72129	computerized axial tomography, thoracic spine; with contrast material
72130	computerized axial tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections

HCPCS	Explanation
72131	computerized axial tomography, lumbar spine; without contrast material
72132	computerized axial tomography, lumbar spine; with contrast material
72133	computerized axial tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72192	computerized axial tomography, pelvis; without contrast material
72193	computerized axial tomography, pelvis; with contrast material(s)
72194	computerized axial tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
73200	computerized axial tomography, upper extremity; without contrast material
73201	computerized axial tomography, upper extremity; with contrast material(s)
73202	computerized axial tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
73700	computerized axial tomography, lower extremity; without contrast material
73701	computerized axial tomography, lower extremity; with contrast material(s)
73702	computerized axial tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
74150	computerized axial tomography, abdomen; without contrast material
74160	computerized axial tomography, abdomen; with contrast material(s)
74170	computerized axial tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
76355	computerized tomography guidance for stereotactic localization
76360	computerized tomography guidance for needle biopsy, radiological supervision and interpretation
76365	computerized tomography guidance for cyst aspiration, radiological supervision and interpretation
76370	computerized tomography guidance for placement of radiation therapy fields
76375	coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging, or other tomographic modality
76380	computerized tomography, limited or localized follow-up study
G1031	computerized tomographpy bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
G1032	computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) e.g., radius, wrist, heel)

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient **Cardiac Catheterization** are:

HCPCS	Explanation
93501	right heart catheterization
93503	insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
93505	endomyocardial biopsy
93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
93510	left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511	left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown
93514	left heart catheterization by left ventricular puncture
93524	combined transseptal and retrograde left heart catheterization
93526	combined right heart catheterization and retrograde left heart catheterization
93527	combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization
93530	Right heart catheterization, for congenital cardiac anomalies
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
93536	percutaneous insertion of intra-aortic balloon catheter
93539	injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass
93540	injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries

HCPCS	Explanation
93541	injection procedure during cardiac catheterization; for pulmonary angiography
93542	injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
93543	injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544	injection procedure during cardiac catheterization; for aortography
93545	injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)
93555	imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
93556	imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)
93561	indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
93562	indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
93571	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel
93572	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient **MRI** are:

HCPCS	Explanation
70336	magnetic resonance (eg, proton) imaging, temporomandibular joint
70540	magnetic resonance (eg, proton) imaging, orbit, face, and neck
70541	magnetic resonance angiography, head and/or neck, with or without contrast material(s)
70551	magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
71550	magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy)
71555	magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72141	magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72196	magnetic resonance (eg, proton) imaging, pelvis
72198	magnetic resonance angiography, pelvis, with or without contrast

HCPCS	Explanation
	material(s)
73220	magnetic resonance (eg, proton) imaging, upper extremity, other than joint
73221	magnetic resonance (eg, proton) imaging, any joint of upper extremity
73225	magnetic resonance angiography, upper extremity, with or without contrast material(s)
73720	magnetic resonance (eg, proton) imaging, lower extremity, other than joint
73721	magnetic resonance (eg, proton) imaging, any joint of lower extremity
73725	magnetic resonance angiography, lower extremity, with or without contrast material(s)
74181	magnetic resonance (eg, proton) imaging, abdomen
74185	magnetic resonance angiography, abdomen, with or without contrast material(s)
75552	cardiac magnetic resonance imaging for morphology; without contrast material
75553	cardiac magnetic resonance imaging for morphology; with contrast material
75554	cardiac magnetic resonance imaging for function, with or without morphology; complete study
75555	cardiac magnetic resonance imaging for function, with or without morphology; limited study
75556	cardiac magnetic resonance imaging for velocity flow mapping
76093	magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
76094	magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
76390	Magnetic resonance spectroscopy
76400	magnetic resonance (eg, proton) imaging, bone marrow blood supply

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient **Radiation Therapy** are:

HCPCS	Explanation
77261	therapeutic radiology treatment planning; simple
77262	therapeutic radiology treatment planning; intermediate
77263	therapeutic radiology treatment planning; complex
77280	therapeutic radiology simulation-aided field setting; simple
77285	therapeutic radiology simulation-aided field setting; intermediate
77290	therapeutic radiology simulation-aided field setting; complex
77295	therapeutic radiology simulation-aided field setting; three-dimensional
77299	unlisted procedure, therapeutic radiology clinical treatment planning
77300	basic radiation dosimetry calculation, central axis depth dose, TDF, NSD gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment, only when prescribed by the treating physician
77305	teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)
77310	teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)
77315	teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77321	special teletherapy port plan, particles, hemibody, total body
77326	brachytherapy isodose calculation; simple (calculation made from single plane, one to four sources/ ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327	brachytherapy isodose calculation; intermediate (multiplane dosage calculations, application involving five to ten sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	brachytherapy isodose calculation; complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)
77331	special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	treatment devices, design and construction; simple (simple block, simple bolus)
77333	treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	treatment devices, design and construction; complex (irregular blocks,

HCPCS	Explanation
	special shields, compensators, wedges, molds or casts)
77336	continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	special medical radiation physics consultation
77399	unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services
77401	radiation treatment delivery, superficial and/or ortho voltage
77402	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV
77404	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV
77406	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater
77407	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 6-10 MeV
77409	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 11-19 MeV
77411	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater
77412	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); up to 5 MeV
77413	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 6-10 MeV
77414	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 11-19 MeV
77416	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 20 MeV

HCPCS	Explanation
	or greater
77417	therapeutic radiology port film(s)
77419	weekly radiation therapy management; conformal
77420	weekly radiation therapy management; simple
77425	weekly radiation therapy management; intermediate
77427	radiation treatment management, five treatments
77430	weekly radiation therapy management; complex
77431	radiation therapy management with complete course of therapy consisting of on or two fractions only
77432	stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)
77470	special treatment procedure (eg, total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)
77499	unlisted procedure, therapeutic radiology clinical treatment management
77600	hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)
77605	hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)
77610	hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
77620	hyperthermia generated by intracavitary probe(s)
77750	infusion or instillation of radioelement solution
77761	intracavitary radioelement application; simple
77762	intracavitary radioelement application; intermediate
77763	intracavitary radioelement application; complex
77776	interstitial radioelement application; simple
77777	interstitial radioelement application; intermediate
77778	interstitial radioelement application; complex
77781	remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	remote afterloading high intensity brachytherapy; 5-8 source positions or catheters
77783	remote afterloading high intensity brachytherapy; 9-12 source positions or catheters
77784	remote afterloading high intensity brachytherapy; over 12 source positions or catheters
77789	surface application of radioelement
77790	supervision, handling, loading of radioelement
77799	unlisted procedure, clinical brachytherapy

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient **Angiography** are:

HCPCS	Explanation
75600	aortography, thoracic, without serialography, radiological supervision and interpretation
75605	aortography, thoracic, by serialography, radiological supervision and interpretation
75625	aortography, abdominal, by serialography, radiological supervision and interpretation
75630	aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
75650	angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation
75658	angiography, brachial, retrograde, radiological supervision and interpretation
75660	angiography, external carotid, unilateral, selective, radiological supervision and interpretation
75662	angiography, external carotid, bilateral, selective, radiological supervision and interpretation
75665	angiography, carotid, cerebral, unilateral, radiological supervision and interpretation
75671	angiography, carotid, cerebral, bilateral, radiological supervision and interpretation
75676	angiography, carotid, cervical, unilateral, radiological supervision and interpretation
75680	angiography, carotid, cervical, bilateral, radiological supervision and interpretation
75685	angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation
75705	angiography, spinal, selective, radiological supervision and interpretation
75710	angiography, extremity, unilateral, radiological supervision and interpretation
75716	angiography, extremity, bilateral, radiological supervision and interpretation
75722	angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation
75724	angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation
75726	angiography, visceral, selective or supraselective, (with or without flush aortogram), radiological supervision and interpretation
75731	angiography, adrenal, unilateral, selective, radiological supervision and interpretation

HCPCS	Explanation
75733	angiography, adrenal, bilateral, selective, radiological supervision and interpretation
75736	angiography, pelvic, selective or supraselective, radiological supervision an interpretation
75741	angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
75743	angiography, pulmonary, bilateral, selective, radiological supervision and interpretation
75746	angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
75756	angiography, internal mammary, radiological supervision and interpretation
75744	(complete procedure) has been deleted, see 36000-36015, 36400-36425 for intravenous procedure and 75743
75790	angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation
75801	lymphangiography, extremity only, unilateral, radiological supervision and interpretation
75803	lymphangiography, extremity only, bilateral, radiological supervision and interpretation
75805	lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation
75807	lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation
75809	shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt), radiological supervision and interpretation
75810	splenoportography, radiological supervision and interpretation
75820	venography, extremity, unilateral, radiological supervision and interpretation
75822	venography, extremity, bilateral, radiological supervision and interpretation
75825	venography, caval, inferior, with serialography, radiological supervision and interpretation
75827	venography, caval, superior, with serialography, radiological supervision and interpretation
75831	venography, renal, unilateral, selective, radiological supervision and interpretation
75833	venography, renal, bilateral, selective, radiological supervision and interpretation
75840	venography, adrenal, unilateral, selective, radiological supervision and interpretation
75842	venography, adrenal, bilateral, selective, radiological supervision and

HCPCS	Explanation
	interpretation
75860	venography, sinus or jugular, catheter, radiological supervision and interpretation
75870	venography, superior sagittal sinus, radiological supervision and interpretation
75872	venography, epidural, radiological supervision and interpretation
75880	venography, orbital, radiological supervision and interpretation
75885	percutaneous transhepatic portography with hemodynamic evaluation, radiologic supervision and interpretation
75887	percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation
75889	hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
75891	hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation
75893	venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
75894	transcatheter therapy, embolization, any method, radiological supervision and interpretation
75898	angiogram through existing catheter for follow-up study for transcatheter therapy, embolization or infusion
75900	exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation
75940	percutaneous placement of IVC filter, radiological supervision and interpretation
75960	transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel
75961	transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation
75962	transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation
75964	transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)
75966	transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation
75968	transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)
75970	transcatheter biopsy, radiological supervision and interpretation

HCPCS	Explanation
75978	transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation
75980	percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation
75982	percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation
75992	transluminal atherectomy, peripheral artery, radiological supervision and interpretation
75993	transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (list separately in addition to code for prima procedure)
75994	transluminal atherectomy, renal, radiological supervision and interpretation
75995	transluminal atherectomy, visceral, radiological supervision and interpretation
75996	transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)

The applicable HCPCS codes that a Medicare certified dialysis facility or hospital certified to render outpatient dialysis can report for **dialysis services and supplies** are:

HCPCS	Explanation
A4650	Centrifuge (includes calibrated microcapillary tubes and sealease)
A4655	Needles and syringes for dialysis
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4663	Blood pressure cuff only
A4680	Activated carbon filters for dialysis
A4690	Dialyzer (artificial kidneys) all brands, all sizes, per unit
A4700	Standard dialysate solution, each
A4705	Bicarbonate dialysate solution, each
A4712	Water, sterile
A4714	Treated water (deionized, distilled, reverse osmosis) for use in dialysis system
A4730	Fistula cannulation set for dialysis only
A4735	Local/topical anesthetic for dialysis only
A4740	Shunt accessory for dialysis only
A4750	Blood tubing, arterial or venous, each
A4755	Blood tubing, arterial and venous combines
A4760	Dialysate standard testing solution supplies
A4765	Dialysate concentrate additive, each
A4770	Blood testing supplies (e.g., vacutainers and tubes
A4771	Serum clotting time tube, per box
A4772	Dextrostick or glucose test strips, per box
A4773	Hemostix, per bottle
A4774	Ammonia test paper, per box
A4780	Sterilizing agent for dialysis equipment, per gallon
A4790	Cleansing agent for equipment for dialysis only
A4820	Hemodialysis kit supply
A4850	Hemostats with rubber tips for dialysis
A4860	Disposable catheter caps
A4870	Plumbing and/or electrical work for home dialysis equipment
A4880	Storage tank utilized in connection with water purification system, replacement tank for dialysis
A4900	Continuous ambulatory peritoneal dialysis (CAPD) supply kit
A4901	Continuous cycling peritoneal dialysis (CCPD) supply kit
A4905	Intermittent peritoneal dialysis (PD) kit
A4910	Non-medical supplies for dialysis (i.e., scale, scissors, stop watch, etc)
A4912	Gomco drain bottle

HCPCS	Explanation
A4914	Preparation kit
A4918	Venous pressure clamp, each
A4919	Dialyzer holder, each
A4920	Harvard pressure clamp, each
A4921	Measuring cylinder, any size, each
A4927	Gloves, sterile or non-sterile, per pair
E1510	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate, meter power off, heater and temp control with alarm, IV poles, pressure gauge, concentrate container
E1520	Heparin infusion pump for dialysis
E1530	Air bubble detector for dialysis
E1560	Blood leak detector for dialysis
E1570	Adjustable chair, for ESRD patients
E1575	Transducer protector/fluid barrier, any size, each
E1580	Unipuncture control system for dialysis
E1590	Hemodialysis machine
E1592	Automatic intermittent peritoneal dialysis system
E1594	Cycler dialysis machine for peritoneal dialysissys
E1600	Delivery and/or installation charges fore renal dialysis equipment
E1610	Reverse osmosis water purification system
E1615	Deionizer water purification system
E1620	Blood pump for dialysis
E1625	Water softening system
E1630	Reciprocating peritoneal dialysis system
E1632	Wearable artificial kidney
E1635	Compact (portable) travel hemodialyzer system
E1636	Sorbent cartridges, per case
E1640	Replacement components for hemopdialysis and/or peritoneal dialysis machines that are owned or being purchased by the patient

Note: One of the following diagnosis must be present on the claim: 403.01, 403.11, 403.91, 404.02, 404.12, 404.92, 584.5, 584.6, 584.7, 584.8, 584.9, 585, 586, 788.5, 958.5 for dialysis services and supplies to be an exclusion to SNF PPS bundling provisions.

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for **outpatient surgery** are all the codes from 11040 – 69979 **with some exceptions**. *Codes that are within the list of exceptions* **may not be billed by the hospital** as they fall within the range of minor procedures that the SNF may provide. These exceptions are:

HCPCS	Explanation
10040	acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10060	incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10080	Incision and drainage of pilonidal cyst: simplec
10120	incision and removal of foreign body, subcutaneous tissues; simple
11040	debridement; skin, partial thickness
11041	debridement; skin, full thickness
11042	debridement; skin, and subcutaneous tissue
11055	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions
11057	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions
11200	removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (list separately in addition to code for primary procedure)
11300	shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11305	shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11400	excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms, or legs; lesion diameter 0.5 cm or less
11719	trimming of nondystrophic nails, any number
11720	debridement of nail(s) by any method(s); one to five
11721	debridement of nail(s) by any method(s); six or more
11900	injection, intralesional; up to and including seven lesions
11901	injection, intralesional; more than seven lesions
11920	tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	tattooing, intradermal introduction of insoluble opaque pigments to

HCPCS	Explanation
	correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (list separately in addition to code for primary procedure)
11950	subcutaneous injection of "filling" material (eg, collagen); 1 cc or less
11951	subcutaneous injection of "filling" material (eg, collagen); 1.1 to 5.0 cc
11952	subcutaneous injection of "filling" material (eg, collagen); 5.1 to 10.0 cc
11954	subcutaneous injection of "filling" material (eg, collagen); over 10.0 cc
11975	insertion, implantable contraceptive capsules
11976	removal, implantable contraceptive capsules
11977	removal with reinsertion, implantable contraceptive capsules
15780	dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	dermabrasion; segmental, face
15782	dermabrasion; regional, other than face
15783	dermabrasion; superficial, any site, (eg, tattoo removal)
15786	abrasion; single lesion (eg, keratosis, scar)
15787	abrasion; each additional four lesions or less (list separately in addition to code for primary procedure)
15788	chemical peel, facial; epidermal
15789	chemical peel, facial; dermal
15792	chemical peel, nonfacial; epidermal
15793	chemical peel, nonfacial; dermal
15810	salabrasion; 20 sq cm or less
15811	salabrasion; over 20 sq cm
16000	initial treatment, first degree burn, when no more than local treatment is required
16020	dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small
17000	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first legion
17003	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; second through 14 lesions, each (list separately in addition to code for first lesion)
17004	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions,

HCPCS	Explanation
	including local anesthesia, 15 or more lesions
17110	destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions
17111	destruction by any method of flat warts, molluscum contagiosum, or milia; 15 or more lesions
17250	chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
17340	cryotherapy (co2 slush, liquid n2) for acne
17360	chemical exfoliation for acne (eg, acne paste, acid)
17380	electrolysis epilation, each 1/2 hour
17999	unlisted procedure, skin, mucous membrane and subcutaneous tissue
20000	incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial
20974	electrical stimulation to aid bone healing; noninvasive (nonoperative)
21084	impression and custom preparation; speech aid prosthesis
21085	impression and custom preparation; oral surgical splint
21497	interdental wiring, for condition other than fracture
26010	drainage of finger abscess; simple
29058	application; plaster Velpeau
29065	application; shoulder to hand (long arm)
28075	application; elbow to finger (short arm)
29085	application; hand and lower forearm (gauntlet)
29105	application of long arm splint (shoulder to hand)
29125	application of short arm splint (forearm to hand); static
29126	application of short arm splint (forearm to hand); dynamic
29130	application of finger splint; static
29131	application of finger splint; dynamic
29200	strapping; thorax
29220	strapping; low back
29240	strapping; shoulder (eg, Velpeau)
29260	strapping; elbow or wrist
29280	strapping; hand or finger
29345	application of long leg cast (thigh to toes);
29355	application of long leg cast (thigh to toes); walker or ambulatory type
29358	application of long leg cast brace
29365	application of cylinder cast (thigh to ankle)
29405	application of short leg cast (below knee to toes);
29425	application of short leg cast (below knee to toes); walking or amb type
29435	application of patellar tendon bearing (PTB) cast
29440	adding walker to previously applied cast
29445	application of rigid total contact leg cast
29450	application of clubfoot cast with molding or manipulation, long or short leg

HCPCS	Explanation
29505	application of long leg splint (thigh to ankle or toes)
29515	application of short leg splint (calf to foot)
29540	strapping; ankle
29550	strapping; toes
29580	strapping; Unna boot
29590	Denis-Browne splint strapping
29700	removal or bivalving; gauntlet, boot or body cast
29705	removal or bivalving; full arm or full leg cast
29710	removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.
29715	removal or bivalving; turnbuckle jacket
29720	repair of spica, body cast or jacket
29730	windowing of cast
29740	wedging of cast (except clubfoot casts)
29750	wedging of clubfoot cast
29799	unlisted procedure, casting or strapping
30300	removal foreign body, intranasal; office type procedure
30901	control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
31720	catheter aspiration (separate procedure); nasotracheal
31725	catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
31730	transtracheal (percutaneous) introduction of needle wire dilator/ stent or indwelling tube for oxygen therapy
36000	introduction of needle or intracatheter, vein
36140	introduction of needle or intracatheter; extremity artery
36400	venipuncture, under age 3 years; femoral, jugular or sagittal sinus
36405	venipuncture, under age 3 years; scalp vein
36406	venipuncture, under age 3 years; other vein
36415	routine venipuncture or finger/heel/ear stick for collection of specimen(s)
36430	transfusion, blood or blood components
36468	single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469	single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470	injection of sclerosing solution; single vein
36471	injection of sclerosing solution; multiple veins, same leg
36489	placement of central venous catheter (subclavian, jugular, or other vein) (eg for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy) percutaneous, over age 2
36600	arterial puncture, withdrawal of blood for diagnosis
36620	arterial catheterization or cannulation for sampling, monitoring or

HCPCS	Explanation
	transfusion (separate procedure); percutaneous
36680	placement of needle for intraosseous infusion
44500	introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)
51772	urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51784	electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
51785	needle electromyography studies (EMG) of anal or urethral sphincter, any technique
51792	stimulus evoked response (eg. measurement of bulbocavernosus reflex latency time)
51795	voiding pressure studies (VP); bladder voiding pressure, any technique
51797	intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)
53601	dilation of urethral structure by passage of sound or urethral dilator, male – SUBSEQUENT to initial
53661	dilation of female urethra including suppository and/or instillation – SUBSEQUENT to initial
53670	catheterization, urethra: simple
53675	complicated (may include difficult removal of balloon catheter)
54150	circumcision, using clamp or other device, newborn
54235	injection of corpora cavernosa with pharmacologic agents(s), (eg. papaverine, plentolamine)
54240	penile plethysmography
54250	nocturnal penile tumescence and/or rigidity test
55870	electoejaculation
57160	fitting and insertion of pessary or other intravaginal support device
57170	diaphragm or cervical cap fitting with instructions
58300	insertion of intrauterine device (IUD)
58301	removal of intrauterine device (IUD)
58321	artificial insemination; intra-cervical
58323	sperm washing for artificial insemination
59020	fetal contraction stress test
59025	fetal non-stress test
59425	antepartum care only; 4-6 visits
59426	antepartum care only; 7 or more visits
59430	postpartum care only (separate procedure)
62367	laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural lumbar
62368	laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural sacral
63691	Deleted. To report, see 95970, 95971.
64550	application of surface (transcutaneous) neurostimulator

HCPCS	Explanation
65205	removal of foreign body, external eye; conjunctival superficial
69000	drainage external ear, abscess or hematoma; simple
69090	ear piercing
69200	removal foreign body from external auditory canal; without general anesthesia
69210	removal impacted cerumen (separate procedure), one or both ears
95970	electronic analysis of implanted neurostimulator pulse generator system(eg. rate, pulse amplitude and duration, configuration of wave for, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral neurostimulator pulse generator/transmitter, *without reprogramming*
95971	electronic analysis of implanted neurostimulator… simple brain, spinal cord or peripheral *with intraoperative or subsequent programming*
95972	electronic analysis of implanted neurostimulator …..complex brain, spinal cord or peripheral….with intraoperative or subsequent programming, first hour
95973	electronic analysis of implanted neurostimulator….complex brain, spinal cord or peripheral…with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)
95974	electronic analysis of implanted neurostimulator…complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming with or without nerve interface testing, first hour
95975	electronic analysis of implanted neurostimulator…complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming with or without nerve interface testing, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)
11740	evacuation of subungual hematoma
11043	***only when performed by a PT or OT*** debridement; skin, subcutaneous tissue, and muscle
11044	***only when performed by a PT or OT*** debridement; skin, subcutaneous tissue, muscle, and bone

Effective April 1, 2000, the excluded HCPCS codes for **chemotherapy items** are:

HCPCS	Explanation
J9000	Doxorubicin HCl, 10 mg
J9001	Doxorubicin hydrochloride, all lipid formulations, 10 mg
J9015	Aldesleukin, per single use vial
J9020	Asparaginase, 10,000 units
J9040	Bleomycin sulfate, 15 units
J9045	Carboplatin, 50 mg
J9050	Carmustine, 100 mg
J9060	Cisplatin, powder or solution, per 10 mg
J9062	Cisplatin, 50 mg
J9065	Injection, cladribine, per 1 mg
J9070	Cyclophosphamide, 100mg
J9080	Cyclophosphamide, 200 mg
J9090	Cyclophosphamide, 500 mg
J9091	Cyclophosphamide, 1 g
J9092	Cyclophosphamide, 2 g
J9093	Cyclophosphamide, lyophilized, 100 mg
J9094	Cyclophosphamide, lyophilized, 200 mg
J9095	Cyclophosphamide, lyophilized, 500 mg
J9096	Cyclophosphamide, lyophilized, 1 g
J9097	Cyclophosphamide, lyophilized, 2 g
J9100	Cytarabine, 100 mg
J9110	Cytarabine, 500 mg
J9120	Dactinomycin, 0.5 mg
J9130	Dacarbazine, 100 mg
J9140	Dacarbazine, 200 mg
J9150	Daunorubicin HCl, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9160	Denileukin diftitox, 300 mcg
J9170	Docetaxel, 20 mg
J9180	Epirubicin hydrochloride, 50 mg
J9181	Etoposide, 10 mg
J9182	Etoposide, 100 mg
J9185	Fludarabine Phosphate 50 mg
J9200	Floxuride, 500 mg
J9201	Gemcitabine HCl, 200 mg
J9206	Irinotecan, 20 mg
J9208	Ifosfamide, per 1 gm
J9211	Idarubicin HCl, 5 mg
J9230	Mechlorethamine HCl, (nitrogen mustard), 10 mg
J9245	Injection, melphalan HCl, 50 mg

HCPCS	Explanation
J9265	Paclitaxel, 30 mg
J9266	Pegaspargase, per single dose vial
J9268	Pentostatin, per 10 mg
J9270	Plicamycin, 2,500 mcg
J9280	Mitomycin, 5 mg
J9290	Mitomycin, 20 mg
J9291	Mitomycin, 40 mg
J9293	Injection, mitoxantrone HCl, per 5 mg
J9310	Rituximan, 100 mg
J9320	Streptozocin, 1 gm
J9340	Thiotepa, 15 mg
J9350	Topotecan, 4 mg
J9355	Trastuzumab, 10 mg
J9357	Valrubicin, intravesical, 200 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg
J9390	Vincristine tartrate, per 10 mg
J9600	Porfimer sodium, 75 mg

EFFECTIVE APRIL 1, 2000, THE EXCLUDED HCPCS CODES FOR CHEMOTHERAPY ADMINISTRATION SERVICES ARE:

HCPCS	Explanation
36260	Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)
36261	Revision of implanted intra-arterial infusion pump
36262	Removal of implanted intra-arterial infusion pump
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2
36530	Insertion of implantable intravenous infusion pump
36531	**Revision of implantable intravenous infusion pump**
36532	Removal of implantable intravenous infusion pump
36533	Insertion of implantable venous access port, with or without subcutaneous reservoir
36534	Revision of implantable venous access port and/or subcutaneous reservoir
36535	Removal of implantable venous access port and/or subcutaneous reservoir
36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown (see also 96420-96425)
36823	Insertion of arterial and cenous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites
96405	Chemotherapy administration, intralesional; up to and including 7 lesions
96406	Chemotherapy administration, intralesional; more than 7 lesions
96408	Chemotherapy administration, intravenous; push technique
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour
96412	Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), required the use of a portable or implantable pump
96420	Chemotherapy administration, intra-arterial; push technique
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96423	Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a

HCPCS	Explanation
	portable or implantable pump
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including lumbar puncture
96520	Refilling and maintenance of portable pump
96530	Refilling and maintenance of implantable pump or reservoir
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
Q0084	Chemotherapy administration by infusion technique only, per visit
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit

Effective April 1, 2000, the excluded HCPCS codes for applicable **radioisotope services** are:

HCPCS	Explanation
79030	Radiopharmaceutical ablation of gland for thyroid carcinoma
79035	Radiopharmaceutical therapy for metastases of thyroid carcinoma
79100	Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment
79200	Intracavitary radioactive colloid therapy
79300	Intersitial radioactive colloid therapy
79400	Radiopharmaceutical therapy, nonthyroid, nonhematologic
79420	Intravascular radiopharmaceutical therapy, particulate
79440	Intra-articular radiopharmaceutical therapy

Effective April 1, 2000, the excluded HCPCS codes for customized prosthetic devices are:

HCPCS	Explanation
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin SACH foot
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5310	Knee disarticulation (or through knee), molded socket, SACH foot endoskeletal system, including soft cover and finishing
L5320	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing
L5330	Hip disarticulation, Canadian type; molded socket, endo-skeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5500	Initial, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5505	Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5510	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed

HCPCS	Explanation
L5520	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5560	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, thermoplasic or equal, molded to patient model
L5600	Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system
L5611	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with hydraulic friction swing phase control
L5614	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with pneumatic friction swing phase control
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above or below knee, each
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation

HCPCS	Explanation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket
L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632	Addition to lower extremity, Symes type, “PTB” brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact
L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air cushion socket
L5647	Addition to lower extremity, below knee, suction socket
L5648	Addition to lower extremity, above knee, air cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket
L5654	Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal
L5661	Addition to lower extremity, socket insert, multidurometer, Symes
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or

HCPCS	Explanation
	equal
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal
L5665	Addition to lower extremity, socket insert, multidurometer, below knee
L5666	Addition to lower extremity, socket insert, cuff suspension
L5667	Addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism
L5668	Addition to lower extremity, below knee, molded distal cushion
L5669	Addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism
L5670	Addition to lower extremity, below knee, molded supracondylar suspension (“PTS) or similar
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair
L5677	Addition to lower extremity, below knee, knee joints, polycentric, pair
L5678	Addition to lower extremity, below knee, joint covers, pair
L5680	Addition to lower extremity, below knee, thigh lacer nonmolded
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5684	Addition to lower extremity, below knee, fork strap
L5686	Addition to lower extremity, below knee, back check (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness
L5700	Replacement, socket, below knee, molded to patient model

HCPCS	Explanation
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	Replacement, custom shaped protective cover, below knee
L5705	Replacement, custom shaped protective cover, above knee
L5706	Replacement, custom shaped protective cover, knee disarticulation
L5707	Replacement, custom shaped protective cover, hip disarticulation
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical

HCPCS	Explanation
	stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840	Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L5845	Addition, endoskeletal knee-shin system, stance flexion feature, adjustable
L5846	Addition, endoskeletal knee-shin system, microprocessor control feature, swing phase only
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	Addition, endoskeletal system, above knee, flexible protective outer

HCPCS	Explanation
	surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5968	All lower extremity prosthesis, ankle, multi-axial shock absorbing system
L5970	All lower extremity prostheses, foot, external keel, SACH foot
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)
L5974	All lower extremity prostheses, foot single axis ankle/foot
L5975	All lower extremity prostheses, combination single axis ankle and flexible keel foot
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy 11 or equal)
L5978	All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	All lower extremity prostheses, multi-axial ankle/foot, dynamic response
L5980	All lower extremity prostheses, flex foot system
L5981	All lower extremity prostheses, flex-walk system or equal
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prostheses, axial rotation unit
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)
L5988	All lower extremity prostheses, combination vertical shock and multi-axial rotation/torsional force reducing pylon
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	Below elbow, molded socket (Muenster or Northwestern suspension types)
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
L6250	Above elbow, molded double wall socket, internal locking elbow,

HCPCS	Explanation
	forearm
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)
L6320	Shoulder disarticulation, passive restoration (shoulder cap only)
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	Interscapular thoracic, passive restoration (complete prosthesis)
L6370	Interscapular thoracic, passive restoration (shoulder cap only)
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, IIUSMCII or equal pylon, no cover, direct formed
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, direct formed
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, direct formed
L6588	Preparatory, shoulder disarticulation or intrascapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model

HCPCS	Explanation
L6590	Preparatory, shoulder disarticulation or intrascapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed
L6600	Upper extremity additions, polycentric hinge, pair
L6605	Upper extremity additions, single pivot hinge, pair
L6610	Upper extremity additions, flexible metal hinge, pair
L6615	Upper extremity addition, disconnect locking wrist unit
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	Upper extremity addition, flexion-friction wrist unit
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	Upper extremity addition, rotation wrist unit with cable lock
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	Upper extremity addition, stainless steel, any wrist
L6632	Upper extremity addition, latex suspension sleeve, each
L6635	Upper extremity addition, lift assist for elbow
L6637	Upper extremity addition, nudge control elbow lock
L6640	Upper extremity addition, shoulder abduction joint, pair
L6641	Upper extremity addition, excursion amplifier, pulley type
L6642	Upper extremity addition, excursion amplifier,]ever type
L6645	Upper extremity addition, shoulder universal joint, each
L6650	Upper extremity addition, standard control cable, extra
L6660	Upper extremity addition, heavy duty control cable
L6665	Upper extremity addition, Teflon, or equal, cable lining
L6670	Upper extremity addition, hook to hand, cable adapter
L6672	Upper extremity addition, harness, chest or shoulder, saddle type
L6675	Upper extremity addition, harness, figure of eight type, for single control
L6676	Upper extremity addition, harness, figure of eight type, for dual control
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	Upper extremity addition, test socket, elbow disarticulation above elbow

HCPCS	Explanation
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	Upper extremity addition, suction socket
L6687	Upper extremity addition, frame type socket, below elbow or wrist
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation
L6689	Upper extremity addition, frame type socket, shoulder disarticulation
L6690	Upper extremity addition, frame type socket, interscapular-thoracic
L6691	Upper extremity addition, removable insert, each
L6692	Upper extremity addition, silicone gel insert or equal, each
L6693	Upper extremity addition, external locking elbow, forearm counterbalance
L6700	Terminal device, hook, Dorrance or equal, model #3
L6705	Terminal device, hook, Dorrance or equal, model #5
L6710	Terminal device, hook, Dorrance or equal, model #5X
L6715	Terminal device, hook, Dorrance or equal, model #5XA
L6720	Terminal device, hook, Dorrance or equal, model #6
L6725	Terminal device, hook, Dorrance or equal, model #7
L6730	Terminal device, hook, Dorrance or equal, model VLO
L6735	Terminal device, hook, Dorrance or equal, model #8
L6740	Terminal device, hook, Dorrance or equal, model #8X
L6745	Terminal device, hook, Dorrance or equal, model #88X
L6750	Terminal device, hook, Dorrance or equal, model #10P
L6755	Terminal device, hook, Dorrance or equal, model #I OX
L6765	Terminal device, hook, Dorrance or equal, model #12P
L6770	Terminal device, hook, Dorrance or equal, model #99X
L6775	Terminal device, hook, Doffance or equal, model #555
L6780	Terminal device, hook, Doffance or equal, model #SS555
L6790	Terminal device, hook, Accu hook or equal
L6795	Terminal device, hook, 2 load or equal
L6800	Terminal device, hook, APRL VC or equal
L6805	Terminal device, modifier wrist flexion unit
L6806	Terminal device, hook, TRS Grip, Grip 111, VC, or equal
L6807	Terminal device, hook, Grip 1, Grip 11, VC, or equal

HCPCS	Explanation
L6808	Terminal device, hook, TRS Adept, infant or child, VC, or equal
L6809	Terminal device, hook, TRS Super Sport, passive
L6810	Terminal device, pincher tool, Otto Bock or equal
L6825	Terminal device, hand, Dorrance, VO
L6830	Terminal device, hand, APRL, VC
L6835	Terminal device, hand, Sierra, VO
L6840	Terminal device, hand, Becker Imperial
L6845	Terminal device, hand, Becker Lock Grip
L6850	Terminal device, hand, Becker Plylite
L6855	Terminal device, hand, Robin-Aids, VO
L6860	Terminal device, hand, Robin-Aids, VO soft
L6865	Terminal device, hand, passive hand
L6867	Terminal device, hand, Detroit Infant Hand (mechanical)
L6868	Terminal device, hand, passive infant hand, Steeper, Hosmer or equal
L6870	Terminal device, hand, child mitt
L6872	Terminal device, hand, NYU child hand
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	Terminal device, hand, Bock, VC
L6880	Terminal device, hand, Bock, VO
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device

HCPCS	Explanation
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled
L7020	Electronic greifer, Otto Bock or equal, switch controlled
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled
L7035	Electronic greifer, Otto Bock or equal, myoelectronically controlled
L7040	Prehensile actuator, Hosmer or equal, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled
L7170	Electronic elbow, Hosmer or equal, switch controlled
L7180	Electronic elbow, Boston, Utah or equal, myoelectronically controlled
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, Variety Village or equal, switch controlled
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically

HCPCS	Explanation
	controlled
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled
L7260	Electronic waist rotator, Otto Bock or equal
L7266	Servo control, Steeper or equal
L7272	Analogue control, UNB or equal
L7274	Proportional control, 6-12 volt, Liberty, Utah or equal
L7362	Battery charger, six volt, Otto Bock or equal
L7364	Twelve volt battery, Utah or equal, each
L7366	Battery charger, twelve volt, Utah or equal

ADDENDUM 2

PROFESSIONAL (PC) and Technical (TC) INDICATORS

The PC/TC indicator in the Medicare Physician Fee Schedule (MPFS) will be used in the SNF fee schedule *to identify the applicability of technical and/or physician component for the HCPCS codes*. The following table describes intermediary processing for the PC/TC indicator when the SNF provides the service or receives the service under arrangement and subesquently bills for the service.

Intermediary standard systems requirements are as follows:

- **Pay** if PC/TC codes is 3,5,7,9
- **Pay** if PC/TC 1 and modifier TC are present, ***otherwise reject***
- **Reject** if PC/TC indicator is 0,2,6 or 8
- **Reject** if PC/TC code =4 ***unless the HCPCS code is for a service listed as an exception to Part A PPS in section IV.***

Refer to the following PC/TC Indicator Chart (Pg. 2)

PC/TC INDICATOR	**SNF Consolidated Billing/ Payment Policy for Intermediaries for MPFS Services**
0	***Physician Service Code***: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical component. They will never be seen with TC or 26 modifier. ***Intermediaries reject the service*** 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 when billed without a modifier includes both the PC and TC. The code can also be submitted using a 26 or TC modifier to bill just the PC or TC of that service (e.g., G0030, G003026 and G0030TC). ***Intermediaries pay the service*** when submitted with the TC modifier If a global code is submitted, e.g., G0030 with no modifier, reject the service and notify the SNF to resubmit only the TC. If modifier 26 is submitted, reject the service and notify the SNF that the 26 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 indicator of 2 signify services that only have a TC ***Intermediaries pay these without a modifier***
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. ***Reject the service and notify the SNF to resubmit the service, u***sing the code that represents the TC only.
5	***"Incident To" Codes:***: These codes are not considered physician services in the services in the SNF setting. ***Intermediary pays.***
6	***Laboratory Physician Interpretation Codes:*** These codes are for physician services to interpret lab tests. Intermediaries do not pay for these services. ***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***
7	***Physician Therapy Services:*** These services are only billable by the SNF to the intermediary. ***Intermediary pays.***
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 88141, 85060, and P3001-26. A TC indicator is not applicable. ***Intermediaries do not pay for these services***. 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. ***Intermediary pays***.