Understanding SNF Consolidated Billing

An Introduction To Consolidated Billing by Amanda Wetzel

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What do I need to know?

- What is Consolidated Billing (CB)?
- How do I check for Interruptions in CB?
- How does a Resident become Part A? Why is this important?
- How does the CB system work? Why is the SNF paying for services?
- Where do I find correct pricing? CMS? MAC Website?
- Which services are excluded? How do I explain to providers?
- Do all providers participate in CB and accept Medicare rates?
- What if I need more help with CB? Who is a good resource?

Abbreviations Key

ABN = Advanced Beneficiary Notice of Non-Coverage

CB = Consolidated Billing

CMS = Centers for Medicare & Medicaid Services

CWF = Common Working File

EMT = Emergency Medical Technician

ER = Emergency Room

ESRD = End Stage Renal Disease

ET = Emergency Treatment

HCPCS = Healthcare Common procedure Coding System

MAC = Medicare Administrative Contractor

PA = Prior Authorization

RSNAT = Repetitive, Scheduled Non-Emergent Ambulance Transport

RT = Round Trip

SNF = Skilled Nursing Facility

NP = Nurse Practitioner

Helpful terms to understand:

Bundled = SNF is responsible for payment under CB. SNF pays the provider per terms of arrangement, typically Medicare Fee Schedule Rate based on site of service. *See CMS Best Practice Guidelines (slide 44)

Excluded = The SNF is not responsible for payment of a Medicare-covered service under CB. Provider bills Medicare Part B for payment consideration.

Non-Covered = Neither Medicare or the SNF will consider for payment under CB. Responsible party and payment terms are determined by contract/provider arrangement.

Medically Necessary = Item, service, action, treatment that is required to maintain or improve patient's health.

Example:

Just because something is Medically Necessary does NOT mean Medicare pays for it.

Example: Toothbrushes and toothpaste…

Is it medically necessary to use these items? YES

Does Medicare ever pay for these items? NO

Who pays for these items during a Part A SNF Stay?

a) The SNF may elect to give to patients, but Medicare money cannot be used to cover.

b) The patients buy these items for themselves.

Covered/NONCovered VS Bunded/Excluded:

FIRST:

Is this item/service/treatment Medically Necessary?

NO – This is NOT covered by Medicare and responsible party is determined by a separate agreement outside of Consolidated Billing.

YES – Medical Necessity has been met and documented – next question…

Covered/NONCovered VS Bunded/Excluded:

SECOND:

Is this item/service/treatment ever paid for by Medicare?

NO – This is NOT covered by Medicare and responsible party is determined by a separate agreement outside of Consolidated Billing.

YES – There are times when Medicare will cover/pay for this – next question…

Covered/NONCovered VS Bunded/Excluded:

THIRD:

Is this item/service/treatment excluded from Consolidated Billing?

NO – There is no reason for this to be considered excluded – the SNF is responsible.

YES – This item is excluded from Consolidated Billing – the provider can bill Part B for payment consideration.

What is Consolidated Billing? When does this system start, pause or end?

What Is Consolidated Billing (CB)?

The term "Consolidated Billing" refers to Medicare's specific set of billing guidelines which apply only to nursing home resident bills that are covered under their Medicare Part A benefit.

(Part A = the first 100 days an ORIGINAL Medicare beneficiary resides in a SNF)

*contracts may mirror CB policy for other payor types – this is not true Consolidated Billing and all CB guidelines set by CMS may not apply.

Part A stay must be ACTIVE, meaning there are no interruptions, suspensions or temporary CB pauses taking place for the billed date of service.

When is CB status suspended?

Reasons for temporary pauses of CB:

- Qualifying Emergency Event – Patient sent to the nearest hospital ER by ambulance to receive immediate, emergency services
- Absence from SNF spans midnight and there is no formal discharge (SNF absence does not exceed 3 midnights)
- Major Category 1 Excluded Procedure/Service done Outpatient at Hospital

*In all above scenarios, CB suspends when resident exits the SNF and does not reinstate until resident has physically returned. ANYTHING provided during a suspension is NOT bundled to the SNF. This includes related RT medically necessary ambulance transports.

When is CB status suspended?

Reasons for temporary pauses of CB:

1) Qualifying Emergency Event – Patient sent to the nearest hospital ER by ambulance to receive immediate, emergency services

When does CB interruption due to an Emergency start/end?

- Emergency Event **Starts: When the EMT intervenes to provide emergency level of care**. The EMT is now deciding what care is necessary to safely transport patient to the ER where additional evaluation/care is provided.
- EMT's are licensed within your state to evaluate and provide emergency level of care and operate all lifesaving machinery and issue medical supplies that are aboard the ambulance.
- Anything provided during an ER visit AND care provided in other areas of the hospital immediately following the ER visit are all excluded from Consolidated Billing.
- Emergency INTERRUPTION **Resolves: After the patient is returned to the SNF.** SNF staff are once again making care decisions with/for the resident.
- (*more about ER/Ambulance Transport in Part 2)

Emergency Claim Common Billing Issues

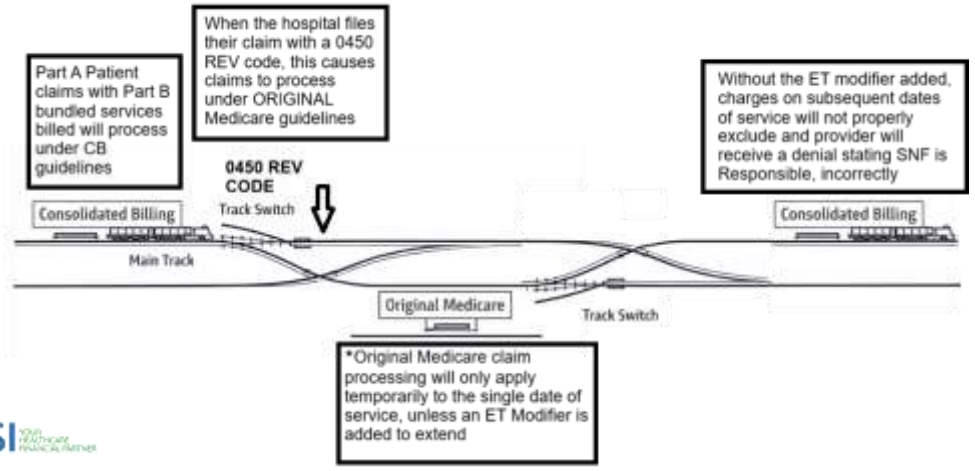
<u>1) Hospital Billing is incorrect</u>:

The initial hospital ER claim must have REV code 0450 listed for the initial ER visit
AND
The ET modifier must be added to all related charges on subsequent dates of service.

This is how CWF is programmed to bypass CB edits and allow the claim to pay the hospital AND the corresponding ambulance claim.

…I like to think of a train on a track…

Emergency Claim Common Billing Issues



Emergency Claim Common Billing Issues

Providers will often claim that when services take place on the “Return To SNF” date, that the SNF is responsible – THIS IS NOT TRUE!

YES, the SNF can bill for this day, but any charges that took place before SNF admission are not the SNF’s responsibility. Since an Emergency pauses Consolidated Billing, we consider the patient to be at a pre-admission status until the emergency is resolved and the patient is back at the SNF.

When you see any Emergency Room claim that spans 2 or more dates of service, the SNF is NOT responsible for ANY of those charges. Errors like a missing modifier or incorrect REV code can cause false denials.

This is our first example of why we always want to process claims as per CMS Policy, not just by what a remit may state!

Emergency Claim Common Billing Issues

2) Billing is not done in correct sequence:

Ambulance providers must wait for hospitals to file the ER claim before submitting an ER transport claim. If there is no hospital ER claim on file to match the ambulance claim to, CWF will incorrectly deny stating SNF is responsible since there is no documented emergency yet – this also affects return from hospital transports.

On the way TO the ER – ambulance providers bill an ER code:
A0427 for Emergency Advanced Life Support (ALS) or A0429 Emergency Basic Life Support (BLS)

On the return trip from the ER – ambulance providers bill a NON emergency code:
Typically A0428 for BLS, A0426 for ALS1 or A0433 for ALS2

Emergency Claim Common Billing Issues

3) Hospital orders ambulance for patients lacking medical necessity* to return them to the SNF:

A patient may require an ambulance to ARRIVE to the ER but that does not automatically mean the patient also requires an ambulance to return to the SNF when exiting the ER.

*Medically Necessary Ambulance Transport = it would be unsafe for a patient to travel by any other means.
Patient requires supervision/care of EMT and/or the use of machinery and/or supplies aboard the ambulance.

CMS Medicare Claims Processing Manual, Chapter 6:
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

- Section 20.1.2.2 - Emergency Services (page 22)
- Section 10.1 - Consolidated Billing Requirement for SNFs (page 7)

When is CB status suspended?

Reasons for temporary pauses of CB:

2) The Patient is absent from the SNF overnight.
   There is no formal discharge
   SNF absence does not exceed 3 midnights

When does the CB interruption due to an overnight SNF Absence start/end?

When a Part A resident is absent from the SNF overnight, this triggers a suspension in Consolidated Billing.

- Suspension starts when the resident exits the SNF *(not at midnight)
- The suspension does not resolve until AFTER the resident is returned to the SNF
- ALL charges for ANY care provided during a suspension are excluded from Consolidated Billing
- Even when patients are held for observation at a hospital setting (non-admitted status), ALL care provided is billed by the hospital directly to Medicare.
- Charges accrued on the same billing date as the patient's return to the SNF are still taking place during the suspension and are correctly billed directly to Medicare by the provider.

When does the CB interruption due to an overnight SNF Absence start/end?

The "Midnight Rule" :

The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before the following midnight. This provision is sometimes referred to as the "midnight rule" (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §20.1, which specifies that an inpatient day ". . . begins at midnight and ends 24 hours later"). A "discharge" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

Overnight Absence Policy :

When a beneficiary is absent from the SNF overnight (i.e., the absence from the SNF spans midnight), the beneficiary's status as a SNF "resident" for CB purposes would end upon the point of departure from the SNF (per the above-described "midnight rule"), and would not resume until the actual point of arrival back at the SNF the next day. Accordingly, that beneficiary would not be considered a SNF "resident" for CB purposes between those two points, so that any offsite services furnished during the interim (such as an overnight sleep study) would not be subject to CB.

Billing guidance and examples: CMS Medicare Claims Processing Manual, Chapter 6:
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

- Section 10.1 – Consolidated Billing Requirement for SNFs (page 6)
- Section 120.2 – Interrupted Stay Policy (page 89)
- Section 40.3.2 – Patient Readmitted Within 30 Days After Discharge (page 48)
- Section 40.3.5.2 - Leave of Absence (page 51)
- Section 110.2.2 - A/B Crossover Edits (page 82)

Overnight SNF Absence Common Billing Issues

- Billing is not done in correct sequence: Providers must wait for SNF to file code 74 for Interrupted Stay on SNF claim to Part A before submitting provider claims to Part B.

  Occurrence span code 74 is what triggers CWF to bypass CB edits and allow payment to providers.

  Ex: Hospital outpatient charges on return to SNF date
  Return to SNF ambulance transport following an overnight absence
  Overnight Sleep Study charges on return to SNF date

  *If SNF goes back and makes a correction to their claim, adding the 74 later, they must let providers know a change was made so they can submit their claim after.

- Hospital orders ambulance for patients lacking medical necessity to return them to the SNF.

  *Medically Necessary Ambulance Transport = it would be unsafe for a patient to travel by any other means.

  The patient requires the supervision/care of an EMT and/or the use of machinery and/or supplies aboard the ambulance.

When is CB status suspended?

Reasons for temporary pauses of CB:

3) Major Category 1 Excluded Procedure/Service
*Must be provided in an Outpatient Hospital setting

Major Category 1 CB "Interruption"

These are certain services that cause the entire claim to be become excluded!

Identified in Major Category 1 of Excluded Services

(We will talk more about these excluded services later)

Examples (including but not limited to):

- MRI and CT Scan done in hospital setting (not freestanding radiology clinic)
- Surgical procedures that are beyond the scope of the SNF done in hospital outpatient (not ASC)
- Round trip, medically necessary transport by ambulance in support of these procedures (not wheelchair van/stretcher limo/taxi/etc.)

How to screen claims for Interruptions in CB?

- Qualifying Emergency Event
  - This will be a claim/bill sent from a hospital or ambulance provider
  - Scan bills for the word "Emergency"
  - Check patient's chart for trips to the ER
  - UB04 Claim forms (or invoiced equivalent) will show a REV code of 0450 for Emergency Room
- SNF Absence Spans Midnight
  - Check for consecutive dates of service billed on one claim/occurrence

  *Statement/Roster-style bills will be more difficult to identify – you may need to verify overnight absence in the patient's chart.

  ** "Hospital Stay Less Than 24 Hours" can still mean interruption spanned midnight
- Excluded Services that cause an Interruption in Consolidated Billing
  - This can usually not be determined at first glance; you will need to research every code billed for the occurrence and see if any item(s) is/are excluded in the specific scenario provided
  - "Major Category 1 Excluded Services" are only excluded when provided in a hospital setting and cause normally "bundled" codes to become excluded – any other services billed on the same LIDOS (Line Item Date Of Service) also become excluded. So – once you locate a Major Category 1 code on your claim, the entire claim becomes a zero pay!

*Note – Drugs and services excluded by STATUTE are excluded regardless of setting and are not considered an "Interruption" in CB

*More on Major Category Exclusions coming up

How does the Consolidated Billing system work?

Who Qualifies For The CB Program?

To become Part A, the patient must meet the following requirements:

1) Be enrolled in original Medicare during 3 day qualifying hospital stay
   - The parameters of what Medicare covers does not change in a SNF setting
   - Any time Consolidated Billing is not in play, the patient reverts back to original Medicare
   - Level of care is established during 3 day stay = rate SNF receives from Medicare to cover care
2) Be enrolled at a Medicare-certified SNF within 30 days of hospital discharge (when appropriate within 30 days)
3) Require skilled-level of daily nursing or rehab services at admission and ongoing
   - A change in patient medical needs can cause a change in daily rate amount
   - Residents no longer requiring skilled daily nursing or rehab services will discharge Part A Stay

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How Does The CB System Work?

Medicare-Certified SNFs receive a daily payment of Medicare funds for each in-house Part A resident, during their covered 100 days. The SNF is then responsible for providing all Medicare covered services (with limited exclusions).

When the SNF cannot provide the patient with needed care, they enlist the help of other providers. These providers then look to the SNF for payment.

*Unless care has been excluded from the SNF bundle,

the SNF is responsible for payment. But how much should the SNF pay?

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How Does The CB System Work?

If we think of the amount of money that the SNF receives from Medicare as an "allowance" we can understand why it's in the SNF's best interest to only pay the Medicare Rate… If we take in $10 for the week, but then pay out $25.00 on a single service, this is not sustainable.

How much does the SNF pay for services?

The SNF is REQUIRED to have a formal arrangement on file with any entity that provides care/services to the SNF's residents. (more on this later)

Although there is no statute set by CMS for what amount the SNF must pay a provider, the industry standard is for the SNF to pay providers the same as when providers are paid by Medicare Part B – aka "The Medicare Rate"

What is the Medicare Fee Schedule?

"The Medicare Fee Schedules" consist of "Medicare Allowable Rates" assigned to services based on:

- Geographical location
- Site of service and
- Date of service.

What is the Medicare Fee Schedule?

Physician Fee Schedule – payment rates paid to physicians for their services.

CMS Pricing Tool is a resource offered by CMS to look up Physician rates, however, these services are often professional and not the SNF's responsibility to pay.

Physicians correctly bill their professional services directly to Medicare Part B

(more on how to identify excluded Physician professional services, later).

What is the Medicare Fee Schedule?

Hospital Fee Schedule: has 2 systems

- APC (Ambulatory Payment Classification): price grouping for services done in hospital outpatient based on clinical similarity – Example: x-ray of wrist = x-ray of elbow
- OPPS (Outpatient Prospective Payment System) – payment packaging by Status Indicator (Chapter 4) – one payment made for specific multiple services done in a single visit

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APCs are the OPPS unit of payment. CMS assigns individual services (HCPCS codes) to APCs based on similar clinical characteristics and similar costs. The APC payment rate and co-payment calculated apply to each service within the APC fee schedule. CMS determines a national unadjusted APC payment rate. In this example for **HCPCS 86902**, the unadjusted APC rate is **$215.43**

To account for geographic differences in input prices, CMS further adjusts the labor portion of the national unadjusted payment rate (60 percent) (A) by the hospital wage index (C) for the area or CBSA [Core Based Statistical Area] where service is provided. CMS does not adjust the remaining 40 percent for non-labor (B). In this example, Bowling Green, KY was used and the final wage index adjusted Medicare Allowable amount is **$192.63.**

APC Payment Calculation

Code		86902	
Date		9/14/2018	
National Unadjusted APC Payment Rate	**$**	**215.43**	
Labor %		60%	
Labor Rate	$	129.26	A
Non Labor	$	86.17	B
CBSA = 14540			
Wage Index		82.36%	C
Labor Rate	$	106.46	D = (A x C)
Adjusted Rate	**$**	**192.63**	B + D = Total

Other factors contributing to pricing adjustments can also be related to the hospital type. For example, unlike traditional hospitals (which are paid under the prospective payment system), Medicare pays Critical Access Hospitals (CAHs) based on each hospital's reported costs.

Other pricing adjustments are made for (including but not limited to):

- Medicare Dependent Hospitals (MDHs)
- Sole-Community Hospitals (SCHs)
- Rural Emergency Hospitals (REHs)
- Low-Volume Hospitals

Your hospital should disclose in your provider arrangement if they have been approved as a specialty hospital location with specific pricing.

The SNF **IS RESPONSIBLE** for these charges.

v Code	HCPCS	Date of Service	Description	Mod	Source	Edit	PC/TC	Status	NCCI	Units	Charge	Allow
02	86900	11/11/2020	Blood typing serologic abo		APC			Q1		1	~~69.00~~	~~101.09~~
02	86901	11/11/2020	Blood typing serologic rh(d)		APC			Q1		1	~~21.00~~	~~31.27~~
02	86923	11/11/2020	Compatibility test electric		APC			Q1		2	~~189.00~~	~~269.18~~
90	P9016	11/11/2020	Rbc leukocytes reduced		APC			R		1	620.00	176.19
91	36430	11/11/2020	Blood transfusion service		APC	Cat.If		S		1	1,006.00	362.99

$539.18

Total Charges: 1,855.00
Medicare Allowable Amounts: 940.92

GEND

t Code	Edit Description
I.If	CMS publishes those Minor Surgical Procedures that are INCLUDED within a certain range of codes as Category I.F inclusions. Services directly related to this codes defined as services billed for the same place of service (POS) and line item date of service are also excluded.

cing Code	Pricing Description
C	Price based on Hospital Outpatient APC payments adjusted by regional wage index

tus Code	Status Description
	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
	Paid under OPPS; separate APC payment.
	Paid under OPPS; separate APC payment.

***Since payent for a HCPCS codes with a Q1 status indicator is packaged into any other payments for codes with an S, T or V Status Indicator, on this claim we only pay $539.18. YES - the SNF is RESPONSIBLE for all codes**

What is the Medicare Fee Schedule?

Ambulatory Surgery Center (ASC) – facility fee rates paid to the surgery center – *not to be confused with the Physician Fee Schedule rates paid to the person performing the procedure.

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What is the Medicare Fee Schedule?

Additionally, there are separate files for other categories of codes, as well. These payment rates can also vary by geographical locality and date of service:

- Clinical Laboratory
- Ambulance
- DME (Durable Medical Equipment)
- Drugs
- Carrier Priced Codes (pricing is determined by the MAC and may not be published)

*MACs either release files containing Carrier Priced Codes or make case-by-case decisions and may require supporting documentation to do so.

Where are Fee Schedule (and related) Files?

Carrier Priced Codes – you must contact your MAC for pricing, but the list of codes subject to MAC pricing is here:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Carrier-Specific-Files
*MACs may or may not publish a complete or partial file of codes each year.

Each MAC services specific states – not sure of your MAC? More info from CMS, here:
https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs

- Noridian
- WPS
- Novitas
- First Coast
- NGS
- Palmetto
- CGS

Where are Fee Schedule (and related) Files?

*Files have scheduled updates quarterly/yearly which can be retroactive and changes can also occur any time!

General Info (locality, etc): https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo

Physician Fee Schedule Info: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

CMS Pricing Lookup Tool: https://www.cms.gov/medicare/physician-fee-schedule/search/overview

OPPS (addendum A and B files): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

ASC (addendum AA and BB files) : https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

DME: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

Drugs: https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price

Labs: https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files

Where are Fee Schedule (and related) Files?

*Exclusions based on scenario/setting are not identified on fee schedules and are also subject to change/update quarterly or retroactively!

Consolidated Billing Overview:
https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling

General Explanation of the 5 Major Categories:
https://www.cms.gov/files/document/general-explanation-major-categories-snf-cb.pdf-1

Major Category Excluded Codes – Part A MAC Update:
https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing/2026-part-mac-update

Specifically Excluded/Unbundled Codes – Part B MAC Update:
https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing/2026-part-b-mac-update

What are some issues to watch out for when downloading CMS files?

Updates – files may have scheduled updates that are yearly or quarterly, but changes can be made at any time and may affect specific dates of service. If changes are effective to retroactive dates, you will need to manually make those changes to the older files. CMS often announces file changes, but does not physically make them on the files.

2025 Part A MAC Update

ADD-

Major Category III. A. - Chemotherapy

- J8611 ORAL METHOTREXATE (JYLAMVO) 7/1/2024
- J8612 ORAL METHOTREXATE (XATMEP) 7/1/2024
- J9075 INJ, CYCLOPHOSPHAMIDE, NOS 4/1/2024
- J9248 INJ MELPHALAN (HEPZATO) 1 MG 4/1/2024
- J9249 INJ, MELPHALAN (APOTEX) 1 MG 4/1/2024
- J9376 INJ POZELIMAB-BBFG, 1 MG 4/1/2024
- J9329 INJ, TISLELIZUMAB-JSGR 10/1/2024

Major Category III. D. - Customized Prosthetic Devices

- L5783 ADD LOW EXT MEC LIMB VOL SYS 4/1/2024
- L5841 ADDITION ENDOSKLETL KNEE-SHI 4/1/2024
- L8720 EXT LOW EXT SENS PROSTHE MEC 10/1/2024
- L8721 RECEPTOR SOLE L8720 REPLACE 10/1/2024

Major Category III. E. - Certain blood clotting factors

- C9172 INJ, BEQVEZ, PER TX DOSE 10/1/2024
- J7165 INJ, HUMAN-LANS, PER I.U 4/1/2024

Major Category IV. A. -Mammography Screening

- 77063 SCREENING DIGITAL BREAST TOMOSYNTHESIS, BILATERAL 01/01/2015

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41

What are some issues to watch out for when downloading CMS files?

Errors – often times, the Part A and Part B MAC files will not match or contain other errors. MACs will incorrectly process claims as a result!

2019 Part B MAC Update

The April 2021 quarterly update includes revisions to the Part B SNF CB files for 2021, 2020, 2019, and 2017.

The revisions to the Part B SNF CB files for 2019 included in this update (effective with the April 5, 2021 implementation of CR 12252) are as follows:

Revisions to 2019 Files

File A

Deletion of the following HCPCS codes effective January 1, 2020:

- J0897
- 64550

The SNF consolidated billing files reflect new codes that have been developed for 2019 and codes that have been discontinued for 2019. In addition, the files reflect any additions and deletions to categories of services excluded from consolidated billing. These files are effective for claims with dates of service on or after 1/01/2019 unless otherwise noted.

File 1 - Part A Stay - Physician Services (see file below)

Services represented by these codes are not subject to skilled nursing facility (SNF) consolidated billing for Medicare beneficiaries in a SNF Part A covered stay. They should be submitted to the Part B MAC or Durable Medical Equipment MAC, as appropriate, for payment consideration.

Some codes when billed globally, or as a separate technical component or professional component billed with a TC or 26 modifier, are excluded from consolidated billing and may be paid separately by the Part B MAC. These codes therefore appear on both File 1 and File 2.

Note: The Healthcare Common Procedure Coding System (HCPCS) code, J0001 was not included in the 2018 annual update to the SNF files. A correction to the coding lists will be implemented in annual 2019 SNF file updates and will be added to File 1 October 2018. The effected HCPCS code for practitioner billing is J0901, will be added to File 1. If you have claims with dates of service from January 1 through December 31, 2018, that have been erroneously denied, you should contact your Medicare Administrative Contractor to have the claims re-opened and re-processed.

The HCPCS code J0170 was erroneously removed from the 2018 file. The effected HCPCS code for practitioner billing will be back dated to January 1, 2018 and added to File 1 with the 2019 SNF file updates. If you have claims with dates of service from January 1 through December 31, 2018, that have been erroneously denied, you should contact your Medicare Administrative Contractor to have the claims re-opened and re-processed.

Using the 2019 Part B MAC Update as an example – code J9176 was deleted from File 1 in error in 2018. This announcement states the issue will be corrected and it was for 2019, but the error resumed in 2020 and every following year through 2026. So, this means every claim that was filed for code J9176 by a Part B provider servicing a patient in a Part A SNF Stay was denied in error and providers were instructed to bill the SNF. If SNFs do not recoup their funds and make sure providers are aware they need to reprocess these claims, this means that SNFs paid out these funds in error.

42

What is excluded from Consolidated Billing?

What Is An Excluded Service?

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: **There are a limited number of services excluded from consolidated billing, and therefore, separately payable.**

*__Non__-Medicare-Covered Services are not the same as Medicare **COVERED** Consolidated Billing Excluded Services

Codes excluded by statute

(always excluded in any setting) example:

- Professional Services
- Global Services
- Specifically Excluded
- Certain Drugs

The 5 Major Categories of Excluded Services:

(excluded by specific scenario) example:

- Beyond the Scope Of SNF Services (Hosp Outpatient)
- Chemotherapy Exclusions
- Specific ASC exclusions by Payment Indicator

*above examples are “including but not limited to”

Exclusions Explained: Professional Services

Physician billing can include both Professional and Technical components or are entirely professional in nature (ex: routine office visits, observation, supervision, etc).

Physicians' professional services furnished to SNF residents are not subject to CB and, thus, are still billed separately to the Part B carrier by the provider, while technical services are bundled.

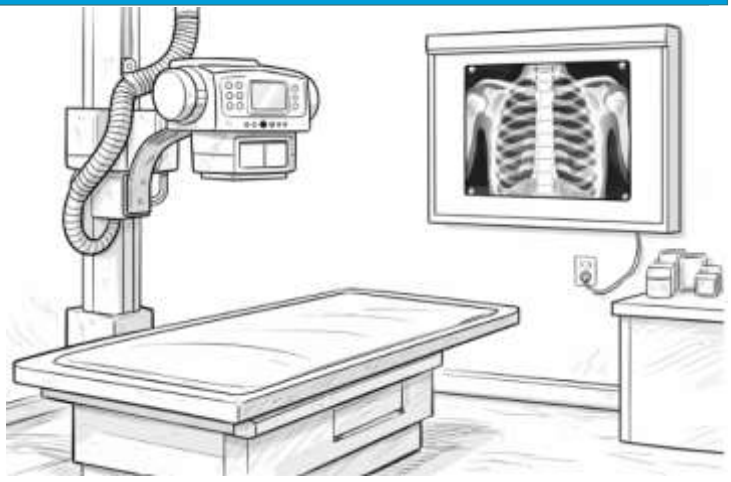
Exclusions Explained: Professional Services

- Professional Services – no technical component (excluded , billed to Part B by provider)Examples:
- office visits
- Observation
- supervision, etc

*you are paying a person for their time and expertise.

Exclusions Explained: Professional Services

- Technical Services – no professional component (bundled, billed to SNF by provider)Examples:
- facility fees
- provision of equipment
- costs associated with operating or maintaining machinery, etc



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Exclusions Explained: Global Services

Physician services which include Professional and Technical components are referred to as "Global Services". Since only the technical portion is bundled to the SNF, the charges must be separated and billed accordingly.

- Global Services – contain both a professional and a technical component
  - Most Global Services can be billed with modifiers to establish separation of charges
    - 26 Modifier = Professional Component (billed to Medicare by provider)
    - TC Modifier = Technical Component (billed to SNF by provider)

Example: X-Ray Code 70360 = machine performing exam and provider interpreting report (global)
70360 (26) = physician's interpretation of report (professional)
70360 (TC) = cost of machine producing report (technical)

- Certain "Global Codes" are not compatible with modifiers. Instead, separate codes exist for each component.

Example: EKG Complete Code 93000 = EKG machine producing report and professional interpretation of report
Technical Code 93005 = machine producing report - Billed to SNF by provider
Professional Code 93010 = physician interpretation of report - Billed to Medicare by provider
*Hospitals are exempt from needing TC on claims, as they do not bill professional charges

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5 Major Categories Explained: Category 1.A-E: Hospital Outpatient Exclusions

Major Category I Excluded Services

- Must be provided in a hospital outpatient setting
- All directly related services become exclusions in this scenario
- Patient must meet medical necessity for hospital setting (medical reason why they require hospital)
- Patient's need for procedure itself must be considered reasonable and necessary.

*Medicare Denials may occur when the hospital bills incorrect/outdated HCPCS, inappropriate HCPCS or with an incorrect REV code.

Example – G0463 facility fee must be billed with REV code of 0510 for hospital office visits. CPT codes 99201-99205 and 99211-99215 are invalid for OPPS billing since 2014, but are commonly still used by hospital billers, in error, causing denials.

Major Category I - Exclusion of Services Beyond the Scope of a SNF

These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH) only, **not by a SNF**, and are excluded from SNF PPS and CB for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery **HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 – 69990** (except HCPCS codes listed as inclusions under Major Category I.F) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

NOTE: Services billed by providers to the Medicare Administrative Contractor represent the facility charge portion for those services.

Major Category I. is further broken down into subcategories:

A. Computerized Axial Tomography (CT) Scans
B. Cardiac Catheterization
C. Magnetic Resonance Imaging (MRIs)
D. Radiation Therapy
E. Angiography, Lymphatic, Venous and Related Procedures
F. Outpatient Surgery and Related Procedures– INCLUSION (see note below)

Note: Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing **minor procedures that can be performed in the SNF itself**. The physician's service itself may be excluded for the codes listed (identified in the Carrier A/B MAC files) in this section, however, when these codes are billed by the hospital they are for the technical/facility charge and are not excluded.

5 Major Categories Explained: Category 1.F: Hospital Outpatient INCLUSIONS

Listing surgical procedures done in the hospital setting that are bundled to the SNF is much shorter than those which are excluded, therefore, instead of an "exclusion" list, for Cat 1.F scenario, we have "inclusions"

To Be Excluded (hospital bills Medicare):

- Procedure must be "surgical" in nature
- Hospital setting is required
- Procedure cannot be done safely at SNF

Example of an Exclusion:

- Surgical placement of a pacemaker; could never safely be done in a SNF

Inclusions (hospital bills SNF – Major Category 1.F):

- Procedure is considered "minor" or non-surgical
- Can be performed at the SNF in other scenarios and hospital setting is only required for specific safety issue

Example of an Inclusion:

Extraction of an infected toenail; resident is diabetic and hospital setting is required for safety. Non-diabetic residents can have same procedure safely in other settings.

5 Major Categories Explained: Category 1.G-H: Emergency Services (Hospital and Ambulance)

An "Emergency" for Consolidated Billing Purposes is defined by Medicare as: when an immediate, necessary trip by ambulance, to the nearest Emergency Room, where emergency services are administered to the patient, takes place.

*Patients entering the hospital through the Emergency Department for convenience does not count as a true Medically Necessary Emergency Situation to validate an ambulance transport – even though evaluation and care provided in ER is still excluded from CB.

G. Emergency Services

These services are identified on claims submitted to Part A MACs by a hospital or CAH using revenue code 045x (Emergency Room—"x" represents a varying third digit). Related services with the same line item date of service (LIDOS) are also excluded. Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.

Note: In order to bypass services related to the ER encounter, which are performed on subsequent service dates, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. Please review Change Request 5389 for further information.

H. Ambulance Trips – With Application to Major Category II

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

Which Ambulance Services are not covered vs excluded?

Charges must be medically necessary to be "Medicare-covered" – including (**but not limited to**) ambulance!

- If the patient does not meet medical necessity for the ambulance, the trip is NOT COVERED by Medicare OR the SNF. ABN (Form CMS-R-131) must be issued and ambulance provider bills the resident.

Common occurrences – return to SNF after ER visit. (ABN cannot be used during a true emergency)

*Complete ABN instructions on CMS website : https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

*If hospital orders ambulance but medical necessity is not met, this does not make the SNF responsible.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

Which Ambulance Services are not covered vs excluded?

REMINDER - If the patient meets medical necessity for an ambulance and is transported to the hospital for a non-emergent, non-excluded reason, this is considered a scheduled visit – even if done at the last minute. The transport is bundled to the SNF and no interruption in Consolidated Billing takes place (unless SNF absence spans midnight).

*medically necessary ambulance transport to scheduled appointments are NOT excluded unless:

- Transport is to/from dialysis
- Transport is to/from hospital outpatient for Category 1 excluded service
- Transport takes place pre-admission – including during an interruption/suspension of CB.

5 Major Categories Explained: Category 2.A: Dialysis and ESRD Services

"Other Dialysis Related Services"

*Medically necessary AMBULANCE transport to/from dialysis is also excluded from Consolidated Billing.

*Be aware of the Prior Authorization (PA) Requirement for ambulance providers to obtain on reoccurring ambulance transport

Major Category II - Additional Services Excluded when Rendered to Specific Beneficiaries

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. Services (dialysis, etc.) when the SNF is the place of service, as to receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

NOTE: This category also excludes non-ESRD acute dialysis from SNF CB, as set forth in §20.2.1 of the Medicare Claims Processing Manual, Chapter 6.

A. Dialysis, EPO, Aranesp, and Other Dialysis Related Services for ESRD Beneficiaries

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases: (1) when the services are provided in a RDF (including ambulance services listed under Major Category I. above), (2) home dialysis when the SNF constitutes the home of the beneficiary, and (3) when the drugs EPO or Aranesp are used for ESRD beneficiaries. *Note that SNFs may not be paid for home dialysis supplies.*

5 Major Categories Explained: Category 3.A-B: Chemotherapy and Chemo Admin

CHEMOTHERAPY REMINDER

MOST Medicare-covered Chemotherapy drugs that are in pill-form fall under the prescription drug portion of Consolidated Billing and will be bundled to the SNF, unless excluded for another reason. Usually, oral drugs in pill-form do not meet Major Category III Exclusion Requirements – Oral Methotrexate being one of the few exceptions (added in 2024).

*MOST prescription drugs in pill-form are bundled to the SNF if covered by Medicare unless specifically excluded for another reason.

Major Category III - Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

A. Chemotherapy
B. Chemotherapy Administration

Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services and physician orders must exist to support the provision of chemotherapy. Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

C. Radioisotopes and their Administration
D. Customized Prosthetic Devices
E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.

5 Major Categories Explained: Category 3.A-B: Chemotherapy and Chemo Admin

Chemotherapy Liquid Treatments – provided by shot, injection, IV push or continuous IV CAN meet the criteria for exclusion, as can some associated administration costs.

- If the drug itself is excluded, then site of service is not considered
- If the drug is not fighting a diagnosis of cancer, then it does not meet the criteria for exclusion, even if it is part of the Chemotherapy plan of care.

Example:

Iron infusions treating anemia caused by Chemotherapy are not excluded in this case – anemia is a secondary diagnosis and not excluded since it is not helping to fight the actual cancer.

5 Major Categories Explained: Category 3.C-E: Radioisotopes and Admin, Custom Prosthetics and Hemophilia

C. Radioisotopes and their Administration

D. Customized Prosthetic Devices

E. Hemophilia Exclusions

*Reminder - exclusions must be identified by HCPCS

Major Category III - Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

A. Chemotherapy
B. Chemotherapy Administration

Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services and physician orders must exist to support the provision of chemotherapy. Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

C. Radioisotopes and their Administration
D. Customized Prosthetic Devices
E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.

5 Major Categories Explained: Category 3.E: Hemophilia

This new exclusion is effective for DOS on or after October 1, 2021.

Only HCPCS J7170, J7175, J7179, J7180-J7183, J7185–J7205, J7207, J7209-J7212, have been identified as excluded under the revision as of 10/01/21 and J7213 as of 07/01/2023 (so far). The identified excluded codes are unbundled from consolidated billing and become qualified for separate payment consideration under Medicare Part B.

- Must be provided by and billed to Part B by a licensed Medicare certified provider (not by the SNF)
- Self-administered drugs do not meet the criteria for exclusion

For additional details, please reference:

Medicare Learning Network Matters # MM12272, here: https://www.cms.gov/files/document/mm12272.pdf

and CMS Transmittal # 10866, CR12272, here: https://www.cms.gov/files/document/r10866OTN.pdf

5 Major Categories Explained: Category 4.A-K: Preventative and Screening Services

Billing Reminder

Exclusion is by way of reimbursement.

If residents receive Screening and Preventative Services from an off-site provider, the SNF must pay that provider for services and then bill Part B for reimbursement.

Non-SNF providers will be denied if they try to bill Part B, directly.

Major Category IV - Additional Excluded Preventive and Screening Services

These services are covered as Part B benefits and are not included in SNF PPS. Such services must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22X. Swing Bed providers must use TOB 12X for eligible beneficiaries in a Part A SNF level.

Note: Please access Chapter 18 "Preventive and Screening Services" of the Claims Processing manual for coverage and billing guidance.

A. Mammography
B. Vaccines (Pneumococcal, Flu, Hepatitis B, or Covid-19)
C. Vaccine Administration
D. Screening Pap Smear and Pelvic Exams
E. Colorectal Screening Services
F. Prostate Cancer Screening
G. Glaucoma Screening
H. Diabetic Screening
I. Cardiovascular Screening
J. Initial Preventative Physical Exam
K. Abdominal Aortic Aneurysms (AAA) Screening

5 Major Categories Explained: Category 5.A: Therapy INCLUSION

Billing Reminder

If residents receive Therapy Services from an off-site provider, the SNF must pay that provider for services. MOST therapy services cannot be billed to Part B by the SNF for reimbursement.

Non-SNF providers will be denied if they try to bill Part B, directly.

Major Category V - Part B Services Included in SNF Consolidated Billing

Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents.

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

Therapies listed as Cat V on the annual file are INCLUDED, meaning they are bundled to the SNF for payment: https://www.cms.gov/files/zip/2025-annual-snf-consolidated-billing-hcpcs-update.zip

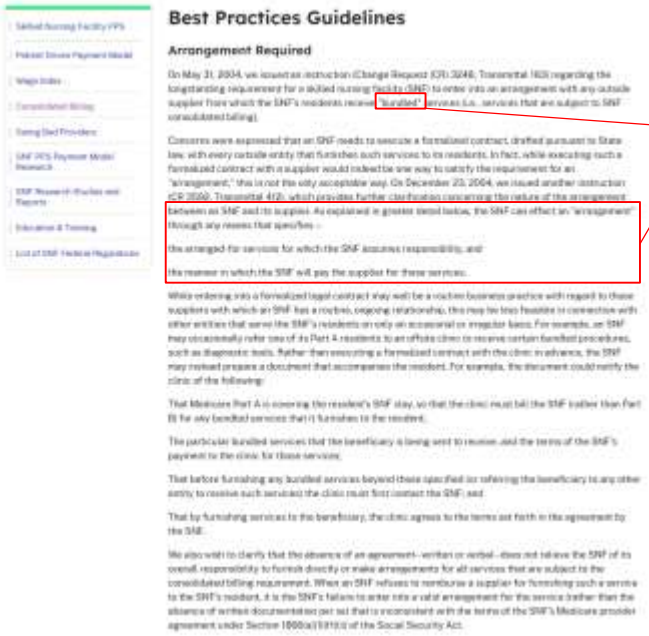
Which providers participate in Consolidated Billing?

Do All Providers Participate in CB?

When a physician or supplier is Medicare Certified, it is generally understood and expected that they will accept the terms of Medicare's Consolidated Billing Fee Schedules, however, it is NOT required.

Medicare-Certified providers can demand up to Medicare's "Limiting Charge" when billing beneficiaries only!

Medicare states SNFs are REQUIRED to enter into a formal arrangement BEFORE any bundled services are rendered to a Part A resident by anyone other than the SNF itself, to ensure all parties are agreeable to the terms of the program, in advance.



Best Practices Guidelines

Arrangement Required

On May 31, 2004, we issued an instruction (Change Request (CR) 3248, Transmittal 1613) regarding the longstanding requirement for a skilled nursing facility (SNF) to enter into an arrangement with any outside supplier from which the SNF's residents receive "bundled" services (i.e., services that are subject to SNF consolidated billing).

Concerns were expressed that an SNF needs to execute a formalized contract, drafted pursuant to State law, with every outside entity that furnishes such services to its residents. In fact, while executing such a formalized contract with a supplier would indeed be one way to satisfy the requirement for an "arrangement," this is not the only acceptable way. On December 23, 2004, we issued another instruction (CR 3592, Transmittal 412), which provides further clarification concerning the nature of the arrangement between an SNF and its suppliers. As explained in greater detail below, the SNF can effect an "arrangement" through any means that specifies –

the arranged-for services for which the SNF assumes responsibility, and

the manner in which the SNF will pay the supplier for these services.

While entering into a formalized legal contract may well be a routine business practice with regard to those suppliers with which an SNF has a routine, ongoing relationship, this may be less feasible in connection with other entities that serve the SNF's residents on only an occasional or irregular basis. For example, an SNF may occasionally refer one of its Part A residents to an offsite clinic to receive certain bundled procedures, such as diagnostic tests. Rather than executing a formalized contract with the clinic in advance, the SNF may instead prepare a document that accompanies the resident. For example, the document could notify the clinic of the following:

That Medicare Part A is covering the resident's SNF stay, so that the clinic must bill the SNF (rather than Part B) for any bundled services that it furnishes to the resident.

The particular bundled services that the beneficiary is being sent to receive, and the terms of the SNF's payment to the clinic for those services.

That before furnishing any bundled services beyond those specified (or referring the beneficiary to any other entity to receive such services) the clinic must first contact the SNF; and

That by furnishing services to the beneficiary, the clinic agrees to the terms set forth in the agreement by the SNF.

We also wish to clarify that the absence of an agreement – written or verbal – does not relieve the SNF of its overall responsibility to furnish directly or make arrangements for all services that are subject to the consolidated billing requirement. When an SNF refuses to reimburse a supplier for furnishing such a service to the SNF's resident, it is the SNF's failure to enter into a valid arrangement for the service (rather than the absence of written documentation per se) that is inconsistent with the terms of the SNF's Medicare provider agreement under Section 1866(a)(1)(H)(i) of the Social Security Act.

Billing Reminder

How does the SNF identify "bundled" services?

The ONLY way to identify which codes are "bundled" or "excluded" is to check CMS files for HCPCS that are listed as an exclusion (or inclusion).

The SNF must alert providers that the ONLY way to meet this REQUIREMENT is to obtain an advance plan of care listing all HCPCS expected to be billed and screen for bundled services.

What can be outlined in provider arrangements?

Provider arrangements should cover all interactions between both entities, from providing care to processing billing – including but not limited to:

- Timely billing cutoff – example: 12 months from DOS or recoup/denial date
- Acceptable proof of timely billing – example: fax/email received receipts, documented correspondence with a business office representative
- Acceptance of appropriate fee schedule rates – this would include outlining how a plan of care is submitted for review before services take place. Make sure providers are aware of the pre-arrangement REQUIREMENT of Consolidated Billing (slide 44).
- Note any needed billing info– example: either a completed appropriate Medicare claim form or all required info on invoices (like including Rev codes on hospital billing or certain modifiers)

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How does a SNF create a provider arrangement?

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices

The CMS Best Practices page offers examples and agreement templates for various provider types. Each template offers appropriate language for the type of provider, but these can be customized to suit the needs of each SNF/provider type and the care needs of residents, so long as Consolidated Billing regulations are not compromised.

Notice

This website provides sample agreements and communication tools for use by SNFs and their suppliers and practitioners. We are providing these samples in response to numerous requests for guidance. The use of the sample documents is not required. Providers, suppliers, and practitioners may chose to modify any of these documents to reflect more closely and accurately the realities of the parties' relationship. These documents only provide sample language, and CMS does not prescribe or endorse the use of any particular format or language.

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What if I need more help with my Consolidated Billing?

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Where can I find CB help?

If you are having an issue with a provider claim, take the proper steps to try and resolve.

- Step One – Check the SNF billing to make sure all was done correctly on your end. LOA dates were recorded correctly, etc. Confirm with your MAC that all looks okay on the SNF side.
- Step Two – Contact your provider office to try and educate them on correct policy with documentation from the Medicare Claims Processing Manual. Escalate internally and request a check for possible errors on the provider end. Request they confirm their billing is correct with their MAC.
- Step Three – If you cannot resolve the issue with the provider and after involving your MAC, you can escalate to your local CMS office. CMS regional offices are displayed on CMS.gov, here: https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices

Recap

- Identify Part A residents to providers before services are rendered and have terms of service in place for care and billing.
- Screen incoming claims for interruptions in Consolidated Billing – providers often bill the SNF in error during these paused periods.
- Be sure to correctly identify exclusions by statute as well as exclusions by circumstance and issue ABN's for non-covered charges.
- Make sure you are applying the most appropriate and current fee schedule based on the type of code, the site of service and date of service when you are paying your providers.
- Be sure providers are separating out professional fees on global services where the SNF is only responsible for the technical portion.
- Don't forget to include preventative/screening and therapy charges (when appropriate) for reimbursement on the SNF's bill to Medicare, when billed by other providers.

Questions?

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