**5 Major Categories**

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| Logo, company name  Description automatically generated  Consolidated Billing  **2022** | **5 Major Categories Skilled Nursing Facility (SNF) Consolidated Billing**  Kris Mastrangelo |

**Skilled Nursing Facility(SNF) Consolidated Billing**

The SNF annual update file contains a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing). The CMS has divided these codes into 5 Major Categories.

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

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

**Major Category III** Additional Excluded Services Rendered by Certified Providers

**Major Category IV** Additional Excluded Preventive and Screening Services

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

**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 Consolidated Billing 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 Consolidated Billing, with exceptions as listed below.

* Note that **anesthesia, drugs** incident to radiology and supplies (**revenue codes 037x, 025x, 027x and 062x)** will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.
* In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery **HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed as inclusions under Major Category I.F)** to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

Services billed by providers to the Fiscal Intermediary/Medicare Administrative Contractor represent the facility charge portion for those services.

**Major Category I is further broken down into subcategories:**

1. **Computerized Axial Tomography (CT) Scans**
2. **Cardiac Catheterization**
3. **Magnetic Resonance Imaging (MRIs)**
4. **Radiation Therapy**
5. **Angiography, Lymphatic, Venous and Related Procedures**
6. **Outpatient Surgery and Related Procedures (Inclusions)**

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

**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.

1. **Emergency Services**

These services are identified on claims submitted to Fiscal Intermediary/Medicare Administrative Contractor by a hospital or Critical Access Hospital (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 to get a match on the LIDOS there must **be** a LIDOS and HCPCS in revenue code 045x.

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.

1. **Ambulance Trips – With Application to Major Category II**

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

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

|  |  |  |
| --- | --- | --- |
| **A. Computerized Axial Tomography (CT) Scans** | **B. Cardiac Catheterization** | **C. Magnetic Resonance Imaging (MRI)** |
| 70450  70460  70470  70480–70482  70486–70488  70490–70492  70496  70498  71250  71260  71270  71275  72125–72133  72191–72194  73200–73202  73206  73700–73702  73706  74150  74160  74170  74174  74175  74176–74178  74261–74262  75635  76380  76497  77011–77013  77078–77079 | 33967–33968  93451–93464  93503  93505  93530–93533  93561–93562  93563–93564  93571–93572  93600  93602–93603  93609–93610  93612–93613  93615–93616  93618–93624  93631  93640–93642  93644  93650  93653–93657  93660  93662 | 70336  70540  70542–70549  70551–70555  70557–70559  71550–71552  71555  72141–72142  72146–72149  72156–72158  72195–72198  73218–73223  73718–73723  73725  74181–74183  74185  75557–75563  76390  76498  77021–77022  77058–77059  77084  C8900–C8914  C8918–C8920 |

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

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| --- | --- | --- | --- |
| **D. Radiation Therapy** | | **E. Angiography, Lymphatic, Venous and Related Procedures** | |
| 19296–19297  77261–77263  77280  77285  77290  77293  77295  77299  77300–77301  77305  77310  77315  77321  77326–77328  77331–77334  77336  77338  77370–77371  77372–77373  77399  77401–77404  77406–77409  77411–77414  77416–77418  77421  77427  77431–77432  77470 | 77499  77520  77522–77523  77525  77600  77605  77610  77615  77620  77750  77761–77763  77776–77778  77781–77784  77789–77790  77799  A4648  A4650  C1715–C1719  C1728  C2616  C2634–C2637  C2639  C2641  C2643  C9725  G0173  G0251  G0339–G0340 | 36598  75600  75605  75625  75630  75635  75650  75658  75660  75662  75665  75671  75676  75680  75685  75705  75710  75716  75722  75724  75726  75731  75733  75736  75741  75743  75746  75756  75774  75790  75801  75803  75805  75807 | 75809–75810  75820  75822  75825  75827  75831  75833  75840  75842  75860  75870  75872  75880  75885  75887  75889  75891  75893–75894  75896  75898  75900  75940  75961–75962  75964  75966  75968  75970  75978  75980  75982  75992–75996  G0269  G0275  G0278 |

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

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| **F. Outpatient Surgery and Related Procedures** | | |
| HCPCS codes 0001T–0021T, 0024T–0026T, or 10021–69990 are exempt from consolidated billing and should be billed directly by the facility except for the following codes representing minor procedures that can be performed in the SNF itself. This includes all other revenue code lines on the incoming claim that have the same line-item date of service (LIDOS). Ambulatory surgeries performed at freestanding or nonhospital ASCs are not exempt from SNF consolidated billing. When the patient is in a SNF Part A stay, the ASC must bill and seek reimbursement from the SNF. Claims from freestanding or nonhospital ASCs will be denied and any payments made will be recouped. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 6, sec.110.2.7) | | |
| 10040  10060  10080  10120  11040–11041  11055–11057  11100–11101  11200–11201  11300  11305  11400  11420  11440  11719–11721  11740  11900–11901  11920–11922  11950–11952  11954  11975–11977  15780–15783  15786–15789  15792–15793  16000  16020 | 29105  29125–29126  29130–29131  29200  29220  29240  29260  29280  29345  29355  29358  29365  29405  29425  29435  29440  29445  29450  29505  29515  29520  29530  29540  29550  29580 | 36405–36406  36430  36468–36471  36600  36620  36680  37195  51701–51703  51772  51784–51785  51792  51795  51797–51798  53601  53660–53661  54150  54235  54240  54250  55870  57160  57170  58301  58321  58323 |

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

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| --- | --- | --- |
| **F. Outpatient Surgery and Related Procedures (continued)** | | |
| 17000  17003–17004  17110–17111  17250  17340  17360  17380  17999  20000  20526  20550–20553  20974  20979  21084–21085  21497  26010  29058  29065  29075  29085–29086 | 29700  29705  29710  29715  29720  29730  29740  29750  29799  30300  30901  31720  31725  31730  32550–32551  36000  36002  36140  36400 | 59025  59425–59426  59430  62367–62368  65205  69000  69200  69210  91123  92977  95970–95975  95990  99183  G0127  G0168  G0268  G0293–G0294 |

**Major Category I: Exclusion of Services Beyond the Scope of a SNF (continued)**

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| --- | --- |
| **G. Emergency Services** | **H. Ambulance Trips** |
| Emergency services are excluded from consolidated billing when submitted to FIs by a hospital CAH using RC 045X. 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. When an ER encounter spans multiple dates of service, the actual date of  service is reported for related services. These related services must have modifier ET appended to them to indicate that they are related to the exempt ER encounter. | 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 (RDF) are also excluded from SNF consolidated billing.  A0425–A0436 A0999 |
| 1. **Additional Surgery HCPCS Exclusions** | |
| C9600–C9608  G0186  G0289  G0299–G0300  G0342–G0343  G0364  92928–92929  92933–92934  92937–92938  92941 |  |

**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.

1. **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.

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

Providers/Suppliers may bill their intermediary or carrier for an ESRD-related diagnostic test, provided the test is outside of the ESRD-facility composite rate. The use of the “Consolidated Billing” modifier would allow these services to be bypassed from the SNF Consolidated Billing edits. Please refer to Change Request 2475 for greater detail.

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

Institutional dialysis services billed only by a RDF are identified by **type of bill 72X**. Services for Method 1 and 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related **diagnosis code 585.6.**

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

**Major Category II: Additional Services Excluded when Rendered to Specific** **Beneficiaries (continued)**

1. **Coding Applicable to EPO and Aranesp Services**

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by ESRD beneficiaries. Darbepoetin alfa (trade name Aranesp) is a drug Medicare approved for use by ESRD

beneficiaries.

When epoetin alfa or darbepoetin alfa are given by the dialysis facility in conjunction with dialysis, **these drugs are excluded** and **must be billed by the RDF**. Instructions for billing RDF services are in publication 100-4, chapter 8.

To distinguish epoetin alfa or darbepoetin alfa given to ESRD beneficiaries from the same drugs given to non-ESRD beneficiaries CMS has developed separate codes. The instructions for billing for non-ESRD epoetin alfa or darbepoetin alfa are located in publication 100-4, chapter 17, section 80.9.

These drugs for non-ESRD use are always bundled to the SNF for beneficiaries in a covered Part A stay.

1. **Hospice Care for a Beneficiary’s Terminal Illness**

Hospice services for terminal conditions are identified with the following **bill types: 81X or 82X.**

Services provided to ESRD beneficiaries, or to beneficiaries who have elected Hospice provided by licensed Medicare Hospice providers are excluded from SNF PPS and consolidated billing. ESRD services provided within the SNF are included in the SNF payment. ESRD services (category IIA) are separately reimbursable only when provided in a renal dialysis facility (TOB 072X) or as home dialysis to patients whose home is the SNF. SNFs may not be paid directly for home dialysis supplies. Hospice services are reimbursable only when billed by a Hospice provider (TOB 081X or 082X).

**Major Category II: Additional Services Excluded when Rendered to Specific** **Beneficiaries (continued)**

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| --- | --- |
| **A. Dialysis, Epoetin, Darbepoetin, and Other Dialysis** **Related Services for ESRD Beneficiaries** | |
| When the epoetin or darbepoetin are used for ESRD beneficiaries, the RDF or hospital may bill for them using codes J0882, J0886, and Q4081. ESRD supplies billable by the RDF and excluded from consolidated billing are listed below. | |
| A4651–A4653  A4657  A4660  A4663  A4671–A4674  A4680  A4690  A4706–A4709  A4714  A4719–A4726  A4728  A4730  A4736–A4737  A4740  A4750  A4755  A4760  A4765  A4766  A4770–A4774  A4802  A4860 | A4870  A4890  A4911  A4913  A4918  A4927–A4931  E1500  E1510  E1520  E1530  E1540  E1550  E1560  E1570  E1575  E1580  E1590  E1592  E1594  E1600  E1610  E1615  E1620  E1625  E1630  E1632  E1635–E1637  E1639  E1699  J0884 |

**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 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**

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**

**Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)**

|  |  |
| --- | --- |
| 1. **Chemotherapy** | |
| J0894  J9000  J9015  J9017  J9019  J9020  J9025  J9027  J9032–J9033  J9034–J9042  J9043  J9045  J9047  J9050  J9055  J9060  J9065  J9070  J9098  J9100  J9120  J9130  J9145  J9150–J9151  J9160  J9171  J9176  J9178–J9179  J9181  J9185  J9200–J9201  J9205–J9207J9208  J9211  J9225  J9228  J9230 | J9245  J9261  J9263–J9264  J9268  J9270–J9271  J9280  J9293  J9295  J9299  J9300  J9302  J9303  J9305  J9306  J9307–J9308  J9310  J9315  J9320  J9325  J9328  J9330  J9340  J9351  J9352  J9354  J9355  J9357  J9360  J9370  J9371  J9390  J9395  J9400  J9600  Q2050 |

**Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)**

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| --- | --- |
| **B. Chemotherapy Administration** | **C. Radioisotopes and their Administration** |
| Chemotherapy administration codes listed with an asterisk (\*) in the file are included in SNF PPS payment for Part A stay when performed alone or with other surgery. These services are excluded from consolidated billing and separately reimbursable when they occur with the same LIDOS as an excluded chemotherapy agent. Codes that do not have an asterisk (\*) are excluded surgery codes for hospitals, including CAHs, and may be billed without a chemotherapy agent.  36260\*–36262\*  36555–36558  36560–36561  36563  36565–36566  36568–36571  36575–36576  36578  36580–36585  36589–36590  36595–36597  36640\*  36823\*  96401–96402\*  96405\*–96406\*  96409\*  96411\*  96413\*  96415\*–96417\*  96420\*  96422\*–96423\*  96425\*  96440\*  96445\*  96446  96450\* | 78804  77014  77750  77761–77763  77776–77778  77785–77787  77789–77790  77799  79005  79101  79200  79300  79403  79440  79445  A9530  A9542–A9543  G3001 |
| **D. Customized Prosthetic Devices**  CMS is clarifying the definition of customized DME. The agency believes that customized items are rarely necessary and are rarely furnished. In accordance with a longstanding definition in 42 CFR, Section 414.224, in order to be considered a customized item, a covered item (including a wheelchair) must be uniquely constructed or substantially modified for a specific patient according to the description and orders of a physician. It is expected to be a one-of-a-kind item fabricated to meet specific needs. The Omnibus Budget Reconciliation Act (OBRA), November 5, 1990, amended the criteria for treatment of wheelchair as a customized item. This alternative definition of customized wheelchairs was never adopted for Medicare payment purposes and should not be confused with the definition of customized items referenced above. |

**Major Category III: Additional Excluded Services Rendered by Certified Providers (continued)**

|  |  |
| --- | --- |
| **B. Chemotherapy Administration** | **C. Radioisotopes and their Administration** |
| 96521–96523  96542\*  C8957\*  Q0083\*-Q0085\* | **D. Customized Prosthetic Devices (continued)**  Payment is made for the lump sum purchase of the item based on the contractor’s individual consideration and judgment of a reasonable payment amount for each customized item. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 20, sec.30.3; *Medicare Program Integrity Manual*, Pub. 100-08, chap. 5, sec. 5.15) |

**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.

Chapter 18 “Preventive and Screening Services” of the Claims Processing Manual provides further coverage and billing guidance.

**A. Mammography**

**B. Vaccines (Pneumococcal, Flu or Hepatitis B)**

**C. Vaccine Administration**

**D. Screening Pap Smear and Pelvic Exams**

**E. Colorectal Screening Services**

**F. Prostate Cancer Screening**

**G. Glaucoma Screening**

**H. Diabetic Screening**

**I. Cardiovascular Screening**

**J. Initial Preventative Physical Exam**

**K. Abdominal Aortic Aneurysms (AAA) Screening**

**Major Category IV: Additional Excluded Preventive and Screening Services (continued)**

|  |  |
| --- | --- |
| 1. **Mammography**   77052 77057 G0202 | **B. Vaccines (Pneumococcal, Flu or Hepatitis B)**  90654  90656–90657  90660  90662  90674  90760  90732  90740  90743–90744  90746–90747  Q2033  Q2035–Q2039 |
| **C. Vaccine Administration**  90465–90468 G0008–G0010 | **D. Screening Pap Smear and Pelvic Exams**  G0101  G0123  G0143–G0145  G0147–G0148  P3000  Q0091 |
| **E. Colorectal Screening Services**  82270  G0104  G0105  G0106  G0120  G0121  G0328  **F. Prostate Cancer Screening**  G0102–G0103  **G. Glaucoma Screening**  G0117–G0118  **H. Diabetic Screening**  82947 82950–82951 |  |

**Major Category IV: Additional Excluded Preventive and Screening Services (continued)**

|  |  |
| --- | --- |
| **I. Cardiovascular Screening**  80061 82465 83718 84478  **J. Initial Preventative Physical Exam**  G0344 G0367  **K. Abdominal Aortic Aneurysm (AAA) Screening**  76706 |  |

**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**.

**Therapies billed with revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)** must be billed by the SNF for all SNF patients whether or not the patient is in a Part A covered stay. These therapies include:

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| --- | --- |
| 64450  90901  92507–92508  92520-92524  92526  92597  92605–92612  92614  92616  95831–95834  95851–95852  95992  96105  96110–96111  96115  96125  97010  97012  97016  97018  97022  97024  97026  97028  97032–97036  97039  97110  97112–97113  97116  97124  97139–97140 | **Physician Services**  Many physician services include both a professional and a technical component, and the technical component is subject to consolidated billing. The technical component of physician services must be billed to and reimbursed by the SNF. (<http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp)>The professional component of physician services and services of certain non- physician practitioners, excluding therapy providers, are excluded from the SNF Part A PPS payment and the requirement for consolidated billing. These professional services must be billed separately by the practitioner to the carrier. This policy applies to the professional component of services rendered by: l Physicians, other than physical, occupational, and speech-language pathology services l Physician assistants, working under a physician’s supervision l Nurse practitioners and clinical nurse specialists working in collaboration with a physician l Certified nurse-midwives l Qualified psychologists l Certified registered nurse anesthetists The technical component of the hospital- based physician service is also exempt when billed on a TOB of 013X or 085X. HCPCS codes 99201–99245 or G0463 must be reported under revenue code 0510 for this exemption. Critical access hospitals billing under method II report the professional fees on TOB 085X using revenue code 096X, 097X, or 098X. The specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing. When a SNF’s Part A resident receives the services of a physician or non-physician practitioner (as listed above) from a rural health clinic (RHC) or a federally qualified health center (FQHC), those services are not subject to consolidated billing because they are furnished by the RHC or FQHC. This subset of RHC or FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 071X and 077X, respectively, to bill for these RHC or FQHC services. |

**Major Category V: Part B Services Included in SNF Consolidated Billing (continued)**

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|  | **Physician Services (continued**  *Medicare Claims Processing Manual*, Pub. 100-04, chap. 6, secs. 20.1.1-20.1.1.2  97150 0029T  97161–97168 G0281  97530 G0283  97532–97533 G0329  97535 G8978-G8999  97537 G9158-G9176  97542 G9186  97597–97598  97602  97605–97608  97610  97750  97755  97760–97762  97799  0019T  (websit[e: http://www.cms.gov/SNFConsolidatedBilling/01\_Overview.asp)](http://www.cms.gov/SNFConsolidatedBilling/01_Overview.asp)) |

**Kris Mastrangelo, OTRL/L, LNHA, MBA**

**President and CEO**

Kris is a nationally recognized keynote speaker with more than 32 years of experience in the Health Care industry with a specialty in the Long Term Post-Acute Care Setting. An Occupational Therapist degree from Tufts University followed by a Master's in Business Administration from Salem State University coupled with a Nursing Home Administrator's License, affords Kris an in-depth perspective into the clinical, financial, and operational components critical for business success. Initially providing direct care as an Occupational Therapist, Kris became familiar with the Medicare, Medicaid, and multiple other reimbursement systems.

Kris is the founder, owner, President and CEO of Harmony Healthcare International, Inc (HHI) an internationally recognized, premier Healthcare Consulting firm. Kris started the company in 2001. Harmony Healthcare International, Inc. (HHI) is a recognized consulting firm that uses a systematic approach in addressing the **C.A.R.E.S.** platform which is trademarked and created by HHI and stands for Compliance, Analysis, Audit, Regulatory, Rehabilitation, Reimbursement, Education, Efficiency and Survey.

Kris speaks on an array of subject matters including Leadership, Compliance, Auditing and Monitoring, QAPI, Analysis, Reimbursement (PDPM, Case Mix, Medicare, Medicaid, HMOs) Regulatory, Survey (Process, IIDR, IIDR, Appeals), Five-Star Quality Rating, Rehabilitation, Program Development, MDS, Facility Assessment, Quality Measures, Value-Based Purchasing, Infection Control, COVID-19, Team Building, Staff Retention, Staff Recruitment and Revenue Cycle Management to name a few.

Kris proclaims that:

**"HHI’s on-site and off-site medical record review process is the nucleus for C.A.R.E.S.**

**optimization and ongoing systems improvement."**

**A person smiling for the camera

Description automatically generated with low confidence**

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