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Contractor Training Conference Call:
Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB)

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C O N T E N T S

P R O C E E D I N G S

[1:04 p.m.]

THE OPERATOR: Good morning, and thank you all for holding. All participants will be able to listen only until the question-and-answer session of the conference.

This conference call is being transcribed and recorded. If you have any objections, you may disconnect at this time.

If you need assistance throughout the call, you may press star-zero.

MS. PALMER: Hello, Pam?

THE OPERATOR: Yes, ma'am?

MS. PALMER: We can hardly hear you.

THE OPERATOR: All right. I'm going to join in again. Just one moment.

[Pause.]

THE OPERATOR: Good afternoon, and thank you for holding. All participants will be able to listen only until the question-and-answer session of the conference.

This conference is being transcribed and

recorded. If you have any objections, you may disconnect at this time.

At this time, I will turn the call over to the leader. Thank you.

Ms. Ann Palmer, you may begin.

Opening Remarks

Ann Palmer

MS. PALMER: Thank you.

As she said, my name is Ann Palmer. I'm from the Division of Provider Information, Planning, and Development at CMS. This is the first contractor training conference call regarding skilled nursing facility PPS and CB. All callers must be CMS employees or employees of CMS fiscal intermediaries, carriers, or durable medical equipment regional carriers. All other callers should hang up at this time.

Right now, I'm going to ask everyone in the room to identify themselves.

Go ahead, please.

MS. ROULAC: My name is Hazeline Roulac. I'm with the Provider Communications Group.

MS. GAY: Ellen Gay with the Division of

Institutional Post-Acute Care.

MS. JANSAK: Kathryn Jansak with the Division of Institutional Post-Acute Care.

MS. TRAZZI: I'm Leslie Trazzi, Provider Billing Group.

MS. LAMBOWITZ: Sheila Lambowitz, Division of Institutional Post-Acute Care.

MR. ULLMAN: Bill Ullman, Division of Institutional Post-Acute Care.

MS. SIDBURY: Kia Sidbury, Division of Institutional Post-Acute Care.

MS. CARMODY: Elizabeth Carmody, Provider Billing Group.

MR. KERR: Jason Kerr, Provider Billing Group.

MR. GEHNE: Wil Gehne, Provider Billing Group

MS. LEONARD: Connie Leonard, Office of Financial Management.

MS. BILLINGSLEY: April Billingsley, Provider Billing Group.

MS. PALMER: Thank you.

We are going to go ahead and have two speakers talk first, and then we are going to open up the line for

any questions that the callers may have. We also ask that any callers, when you call in, please identify yourself and your organization.

At this time, I give the phone call to Sheila Lambowitz.

Remarks by Sheila Lambowitz

MS. LAMBOWITZ: Thank you all for participating in this call.

Over the last year, we have gotten an increasing number of questions related to the SNF Consolidated Billing program and the edits that were put into our claims system in 2002 and 2003. It took us a year to figure out that if we were getting questions, you are probably getting questions as well.

We thought we would take this opportunity to review the SNF PPS and Consolidated Billing policies and to then talk about some of the issues that have come up and to see what questions you have, because we want to make sure that when you get questions from providers that you will be able to feel confident in responding to those questions and making sure that the programs are being run properly.

So I want to thank you again for participating. I'm going to turn it over to Bill Ullman, who is going to walk us through the policy provisions for Consolidated Billing.

SNF PPS and CB: Why Consolidated Billing Is Important To Providers And Suppliers That Serve SNF Residents

Bill Ullman

MR. ULLMAN: Thanks, Sheila. Thank you, Ann.

When I say thanks to Ann Palmer, I mean a really heartfelt thanks to her and all the folks in her shop -- not only for putting together today's call, but they have been a really big help to us in putting out a whole variety of educational and instructional materials on the website, which we will be talking about a little later. So we really appreciate that.

The title of today's session is Skilled Nursing Facility, or SNF, Prospective Payment System, or PPS, and Consolidated Billing, or CB. That is a pretty high ratio of acronyms to real words, even for us, but we are going to be focusing on the CB part of that, the Consolidated Billing part.

I think that one of the few things that pretty

much everybody is in agreement on about Consolidated Billing is that there is an awful lot of confusion about it out in the world. While some of the confusion, as you might expect, comes from SNFs themselves, a lot of it actually comes from other entities that furnish services to the SNF's residents – and that is going to be the particular focus of this discussion. So we really appreciate that everybody is participating on the call today, not only the folks that are here in the room with me but all of you out on the other end of the phone line.

As you may know, there is a PowerPoint presentation associated with today's session which, has been available on the website for a couple of days now. My remarks today might not always exactly coincide with the printed version of the speaker's notes that appear under each slide. It is not that anything I am going to say is unprintable, but it is just that I don't really see the need to follow word-for-word what you already have in front of you.

I will be keying my presentation to each of the slides. So if you happen to have a copy available, you are certainly welcome to pull up a chair, make yourself

comfortable, and follow right along.

That pretty much takes care of the title slide, so moving on to slide 2, we come to the basic definition of SNF Consolidated Billing.

Believe it or not, the basic concept of SNF Consolidated Billing isn't really all that complicated. It essentially requires the SNF to include on its Part A bills most of the services that its residents receive during the course of a covered Part A stay. For those residents in noncovered stays, the SNF still has the Medicare billing responsibility for three specific services: physical, occupational, and speech-language therapy.

That is the basic Consolidated Billing concept in a nutshell. Of course, as with most concepts that sound pretty simple on the surface, the devil is in the details, and the details are what we are going to be talking about this afternoon.

Moving on to slide 3, let's begin with a little background on how all of this got started. In 1997, the Balanced Budget Act, or BBA, created a whole new way to pay for Part A SNF services, a Prospective Payment

System, or PPS, which makes a bundled per diem payment to the SNF for the resident's Medicare-covered stay.

To support the PPS, this legislation also created a Consolidated Billing provision, which requires the SNF to include on its Part A bill the whole package of services that is represented by that bundled PPS per diem payment.

The original Consolidated Billing provision made no distinction between residents in covered and noncovered SNF stays. However, due to systems constraints involved in achieving Year 2000, or Y2K, compliance, we had to postpone implementing the so-called Part B aspect of Consolidated Billing for those SNF residents in noncovered stays.

Then, in 2000, the Benefits Improvement and Protection Act, or BIPA, came along and repealed the Part B aspect of Consolidated Billing altogether, except for physical, occupational, and speech-language therapy. We will have more about that in a little while.

Now on to slide 4. As I mentioned before, the SNF Consolidated Billing provision affects more than just SNFs themselves. Some examples of other entities that

serve SNF residents and, therefore, can be affected by SNF Consolidated Billing include hospital outpatient departments, rehab facilities, physicians and other practitioners, clinics, freestanding lab and x-ray companies, ambulance companies, durable medical equipment suppliers, independent therapists, and others.

Now let's go on to slide 5. A question that we get asked an awful lot is, why do we have to have Consolidated Billing in the first place? I'm sure you all get asked that same question, too. In fact, many of you have probably asked it yourselves.

In order to answer that question, you really have to look at how things were back in the days before we had a Prospective Payment System for SNFs. Back then, suppliers had the completely unrestricted ability to submit bills directly to Part B for their services to an SNF's Part A resident. They didn't have to deal with the SNF at all.

From the Medicare program's perspective, that approach presented some real problems. First, there was the obvious potential for duplicate billing. This happened when the SNF would include a particular service

on the Part A bill that it submitted to its FI for the resident's covered stay, and the supplier would submit a separate Part B bill to the carrier for that very same service.

Because the Part A and Part B sides of our claims processing systems didn't communicate too well with each other back then, more often than not this duplication of payment went completely undetected.

Going beyond the issue of duplicate billing, though, this approach also caused additional financial liability for the beneficiary. Billing a service to Part B that could have been billed to Part A instead meant that the beneficiary incurred out-of-pocket liability for the applicable Part B coinsurance, as well as for any unmet Part B deductible.

Finally, there was the issue of the SNF's responsibility to provide comprehensive oversight of the resident's care and treatment. Now, SNFs have always had this responsibility, even before the PPS, but the pre-PPS approach, which had services being furnished by an assortment of outside suppliers who didn't have to work through the SNF, had the effect of undercutting the SNF's

ability to perform this critical oversight function.

Now we come to slide 6. As I mentioned previously, the law defines Consolidated Billing in terms of services that are furnished to a, quote, unquote, "resident" of a SNF. It all plays out very differently depending on whether Part A is covering a particular resident's stay.

In order to qualify for Part A coverage of the SNF stay, a resident has to meet a number of requirements, such as a prior qualifying hospital stay of at least three consecutive days, a so-called timely transfer requirement to SNF care (generally with 30 days of discharge from that qualifying hospital stay) and a level of care requirement, where the resident has to need and receive daily skilled services that, as a practical matter, require inpatient treatment in a SNF.

Conversely, there are any number of reasons why a particular SNF resident might not qualify for Part A coverage of his or her SNF stay: the lack of a prior qualifying hospital stay, exhaustion of the 100 days of Part A SNF benefits that are available in a benefit period, or not meeting the SNF level of care requirement.

It is worth noting that even if a particular resident doesn't qualify for comprehensive coverage under the Part A SNF benefit -- the room and board and most everything that goes with it -- he or she can still receive coverage under Part B for individual medical and other health services to the extent that there is a Part B benefit that would cover them.

Now let's take a look at slide 7. Since the Medicare status of a resident's SNF stay -- covered versus noncovered -- determines the extent to which Consolidated Billing applies to that resident, it is very important for any outside entities that serve the resident to ascertain that resident's Medicare coverage status in the SNF. They can do this by contacting the SNF directly or by accessing ELGA, Part A eligibility, or ELGB, Part B eligibility. Those particular acronyms refer to a HIPAA-compliant electronic transaction that provides Medicare eligibility information.

Unfortunately, though, this system isn't totally infallible. I'm sure that comes as a great shock to all of you. For example, since SNFs use a monthly billing cycle, an outside entity that serves a SNF's Part

A resident sometimes might submit a claim before the SNF submits its own claim for the resident's Medicare-covered stay. If that happens, the system won't yet show that beneficiary as being a Part A SNF resident.

Now let's turn to slide 8 for a closer look at how the Consolidated Billing provision actually works. We will start with the so-called Part B aspect of Consolidated Billing (for services furnished to SNF residents during a noncovered stay), for the simple reason that this aspect is a whole lot less involved than Consolidated Billing for residents in a covered Part A stay.

Basically, for SNF residents in noncovered stays, only three services are consolidated to the SNF: physical, occupational, and speech-language therapy. An outside therapist who furnishes one of these services to a SNF's Part B resident would do so under a so-called arrangement with the SNF, in which the SNF submits a Part B bill to its FI for the therapy and then pays the therapist.

Further, whenever an institution elects to limit its Medicare SNF certification to only a so-called

distinct part of the overall physical facility, it is only that certified area that is actually considered to be a SNF. This means that therapy services furnished to a beneficiary who resides in the institution's non-certified remainder would not be subject to Part B Consolidated Billing, since that beneficiary wouldn't be considered to be a resident of the Medicare "SNF" at all.

While we are on the subject of therapy services, a word about respiratory therapy. When furnished to a SNF's Part A resident, respiratory therapy is included within the overall package of services for which the PPS makes a bundled per diem payment for the covered Part A stay. When furnished during a noncovered or "Part B" SNF stay, respiratory therapy is not covered at all, for the simple reason that there is no Part B benefit for respiratory therapy.

Now let's turn to slide 9 and the main event: Ccnsolidated Billing for the SNF's Part A residents. This aspect of Consolidated Billing places with the SNF itself the Medicare billing responsibility for just about all of the services that a resident receives during the course of a covered Part A stay, other than those

services that are specifically identified as being excluded from Consolidated Billing. These so-called excluded services remain separately billable to Part B directly by the outside entity that actually furnishes them.

For any service that is subject to Consolidated Billing, the SNF basically has two options. Option 1 is for the SNF to furnish the service in-house with its own resources. Option 2 is for the SNF to obtain the service from an outside entity under an arrangement, and we will talk more about those in a minute.

Since these services are already included in the global PPS per diem payment that the SNF receives for its resident's covered Part A stay, any additional payment for them under Part B would be a duplicate payment. For that reason, the Common Working File, or CWF, will reject claims for services that are subject to Consolidated Billing when they are submitted by any entity other than the SNF itself.

Turning to slide 10, when a SNF chooses to obtain a service that is subject to Consolidated Billing from an outside entity, the SNF has to enter into a valid

arrangement with that entity, in which the SNF includes the service on its Part A bill and the outside entity agrees to look to the SNF rather than to Part B or the beneficiary for its payment.

Medicare doesn't regulate the specific terms of an arrangement, that is, how much the SNF pays its supplier or how quickly, but we do require that there be an arrangement between the two parties in this situation.

Now let's turn to slide 11. Most of the Consolidated Billing discussion tends to focus on the services that are excluded from this provision and that remain separately billable to Part B.

First, though, let's take a brief look at some of the services that are subject to Consolidated Billing, which are included within the SNF's global per diem payment for the resident's covered Part A stay: things like room and board, physical, occupational, and speech-language therapy, supplies, enteral and parenteral nutrition, services furnished as an incident to a physician or other practitioner's professional service, lab and x-ray services, certain kinds of ambulance trips, orthotics and most prosthetics, and most drugs and

biologicals. These services are subject to Consolidated Billing regardless of whether they are rendered on the premises of the SNF or at some other, off-site location.

Turning to slide 12, let's talk about the exclusions from Consolidated Billing. We refer to services that are not subject to Consolidated Billing as excluded services. That can sometimes be a little confusing, because the Medicare program normally uses the term "excluded services" to refer to services that are excluded altogether from Medicare coverage. In the context of SNF Consolidated Billing, though, an excluded service simply means that the service is excluded from the Consolidated Billing requirement itself, and as a result, is separately payable under Part B.

As I mentioned before, there is a relatively short list of services that are not subject to Consolidated Billing and that are separately billable to the carrier or FI when furnished to a Part A SNF resident.

This list of excluded services has evolved over the years. Congress has enacted a number of statutory exclusions through legislation. CMS has created some

additional exclusions administratively in regulations, under which we can identify certain types of exceptionally intensive services as being beyond the general scope of SNF care. More on those a little later.

Now let's take a look at slide 13. This shows some of the specific services that the original Consolidated Billing legislation, the BBA of 1997, excluded from Consolidated Billing and which, therefore, are separately billable to Part B.

First is physician services. While the professional services that a physician performs personally are excluded from Consolidated Billing, services furnished by someone else as an incident to the physician's professional services are subject to Consolidated Billing.

Among the other excluded types of practitioner services are those of physician assistants working under a physician's supervision, nurse practitioners and clinical nurse specialists working in collaboration with a physician, certified nurse midwives, clinical psychologists, and certified registered nurse anesthetists. All of these services are separately

billable to Part B when furnished to a SNF's Part A resident.

In slide 14, we have some additional statutory exclusions from Consolidated Billing. Also excluded are dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit, as well as a medically necessary ambulance round trip to receive the dialysis services off-site. Excluded dialysis services can be furnished and billed directly to Part B by the outside dialysis supplier or end stage renal disease provider.

By contrast, if the SNF chooses to furnish the dialysis services itself, these services would be included within its global PPS per diem for the covered Part A stay and would not be separately billable to Part B.

Similarly, erythropoietin, or EPO, and Darbepoetin Alpha, or DPA, are excluded from Consolidated Billing and billable to Part B whenever they meet the requirements for separate coverage under the Part B EPO benefit.

Also, hospice care that is related to the

resident's terminal condition is excluded from Consolidated Billing, while other care that is unrelated to the terminal condition remains the responsibility of the SNF.

Next, let's take a look at slide 15, which lists some of the administrative exclusions for certain exceptionally intensive outpatient services. These administrative exclusions apply only when the services are furnished at a hospital or a critical access hospital, or CAH.

The specific services that get excluded here are the ones that we identify by Healthcare Common Procedure Coding System, or HCPCS codes, within the following service categories, along with any medically necessary ambulance round trips to receive them: cardiac catheterization; computerized axial tomography, or CAT, scans; magnetic resonance imaging services, or MRIs; ambulatory surgery that requires the use of an operating room or comparable facilities; emergency room services; radiation therapy; angiography; and certain lymphatic and venous procedures.

These exclusions were designed specifically to

address services that require the intensity of the hospital setting in order to be furnished safely and effectively. They don't apply to services that are furnished in freestanding or non-hospital settings.

We periodically issue updated lists of the excluded HCPCS codes for these categories, which appear as Major Category 1 in the annual and quarterly updates for FIs. More on those updates in a little while.

Now let's move to slide 16 and some additional, more recent statutory exclusions from Consolidated Billing. Unlike the administrative exclusions that we just discussed, these services are excluded from Consolidated Billing regardless of the setting, hospital versus freestanding, in which they are furnished. They include certain chemotherapy drugs and their administration, certain radioisotope services, and certain customized prosthetic devices.

Like the administrative exclusions that we discussed in the previous slide, the only services within these categories that are actually excluded are the ones that are specifically identified by HCPCS code. All other services within these categories, the ones that are

not specified by HCPCS code, remain subject to Consolidated Billing.

Moving on to slide 17, a recent amendment to the law has created an additional exclusion effective January 1, 2005, for certain services furnished by Rural Health Clinics, or RHCs, and Federally Qualified Health Centers, or FQHCs. Up until now, all RHC and FQHC services have been subject to Consolidated Billing, but this amendment excludes physician services furnished by these entities, as well as the services of all of the other types of practitioners -- physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, et cetera -- that the law identifies as being excluded from Consolidated Billing.

Now let's turn our attention to a few special situations. Slide 18 deals with therapy services: physical, occupational, and speech-language therapy. As I indicated previously, the law is very emphatic that therapy services are always subject to SNF Consolidated Billing, regardless of whether the resident who receives them is in a covered or noncovered stay. What is more, they are subject to Consolidated Billing even when

performed by a type of practitioner (such as a physician) whose services would otherwise be excluded from Consolidated Billing.

Now let's take a quick look at slide 19 and diagnostic tests. Some diagnostic tests are split into two components: a technical component, representing the test itself, and a professional component, representing the physician's interpretation of the test.

When an outside entity performs a diagnostic test for the SNF's Part A resident, that entity has to look to the SNF for payment of the technical component, regardless of whether the service was performed on-site at the SNF or at some off-site office location. In this situation, the technical component, or TC, is considered a diagnostic test that is subject to Consolidated Billing, while the professional component, or PC, is considered a physician service that is excluded and billed separately to the Part B carrier.

In slide 20, another little policy twist involves preventive and screening services. We inherited this one from the inpatient hospital bundling requirement, which served as the model for SNF

Consolidated Billing.

Preventive and screening services are not included in the SNF's global PPS per diem payment for a covered Part A stay. That is because coverage under the Part A SNF benefit is limited to those services that are considered reasonable and necessary to diagnose or treat a condition that has already manifested itself.

As a consequence, coverage of preventive services (which serve to ward off the occurrence of a condition altogether) or screening services (which detect the presence of a condition that is still in an early, asymptomatic stage) is always reimbursed under Part B and never under Part A. However, since these services don't appear on the list of exclusions from Consolidated Billing, they are subject to Consolidated Billing when furnished to a SNF's Part A residents.

What all of that means is that the SNF itself has to bill for its Part A resident's preventive and screening services, but instead of including them on its Part A bill, the SNF would instead submit a separate Part B claim for them to its FI.

Moving on to slide 21, we will now turn our

attention to some of the online resources that are available to help in dealing with Consolidated Billing issues, which include a variety of publications and instructional materials.

One of the most significant resources involves the periodic updates to the HCPCS codes that are used to identify the services that are excluded from Consolidated Billing. We issue separate annual updates for FIs and carriers, since the CWF edits used to enforce Consolidated Billing vary somewhat between the two.

However, in 2004, we began issuing joint FI-carrier quarterly updates to the separate annual updates. The annual updates are issued in a Change Request, or CR, that is published on or around November 1st of each year and is effective for January 1st of the following year. So be on the lookout for the 2005 updates, which we should be issuing shortly, to take effect in January.

For FIs, the 2004 annual update appears in Transmittal No. 19, which is CR number 2926. This contains a series of lists of excluded codes, except for ambulatory surgery. For that one category, we do the reverse and list the codes for services that are subject

to Consolidated Billing, since that makes for a much shorter list for this one category than would the excluded ambulatory surgery codes.

For carriers, the 2004 annual update appears in Transmittal number B-03-068, or Change Request number 2858. This includes four separate carrier coding files that identify when it is appropriate to submit a separate Part B bill to the carrier. File number 1 lists the excluded physician services. File number 2 lists the excluded professional components of services, which are separately billable when submitted to the carrier with a 26 modifier.

File number 3 lists ambulance codes that are submitted with an "NN" modifier, which are subject to Consolidated Billing. The "N" modifier refers to SNF. File number 4 lists therapy services that are subject to Part B Consolidated Billing for residents in noncovered SNF stays.

Slide 22 displays the URL and web page for the quarterly updates. Let's take just a moment to show you how to locate and use them. This information is for the use of physicians and suppliers that would submit bills

to carriers and DMERCs. It is not for the use of providers, which submit bills to the FIs.

This page contains frequently asked questions for SNF Consolidated Billing, as well as instructions on how to use the four provider files. To locate the four files, click on the year for which you would like to view updates.

Let's take a look at the 2004 updates as an example. Slide 23 displays a screen shot of the 2004 SNF Consolidated Billing update page. As we discussed previously, there are four coding files for the carrier updates: File number 1, which lists, for a Part A stay, the excluded codes for physician services; File number 2, which lists, for a Part A stay, the codes for professional components of services to be submitted with a 26 modifier; File number 3, which lists codes for ambulance trips that are included in the SNF's PPS per diem payment for a Part A stay when submitted with an "NN" modifier; and File number 4, which applies to Part B, or noncovered stays only, which lists bundled therapy services.

To locate codes that can be separately billed

to the carrier outside of Consolidated Billing, look to the right of the screen to select the file you want, or click on the title of that file. For example, clicking on the link to File number 1, "Part A Stay - Physician Services," will take you to a list of some of the codes that can be billed to the carrier while the resident is in a Part A SNF stay.

Turning to slide 24, this shows what File number 1, "Part A Stay - Physician Services," looks like when selected. To find a specific code, just click on the binoculars symbol, type in the code, and click "search" (or "find") to locate the code that you want. If the code doesn't appear in the file, then you know that it is included in SNF Consolidated Billing and you will need to look to the SNF for payment.

File number 2, "Part A Stay - Professional Components of Services to be Submitted with a 26 Modifier," provides a list of codes that represent the professional component of a diagnostic service. When these codes are submitted with a 26 modifier, they are not subject to Consolidated Billing and they can be billed to the carrier.

File number 3, "Part A Stay - Ambulance," provides a list of ambulance codes that are always subject to Consolidated Billing when submitted with an NN modifier.

File number 4, "Part B Stay Only - Therapy Services," is a list of the only codes that are subject to SNF Consolidated Billing for services provided in a noncovered Part B stay. Codes not shown on this file are not subject to Part B Consolidated Billing.

Slide 25 displays some links to additional resources. The first link is the SNF PPS homepage. This web page contains a number of publications and various links that will help you to understand SNF Consolidated Billing.

Currently, there are 10 Medlearn articles available that provide more detail on the various exclusions from Consolidated Billing. Also, the SNF regulations are located in Title 42 of the Code of Federal Regulations or, as we refer to it, 42 CFR.

Finally, before we wrap up the PowerPoint part of the presentation, slide 26 includes a brief preview of coming attractions. Some of our upcoming activities in

the Consolidated Billing area include developing a model agreement that SNFs can use when making arrangements with outside entities for the provision of services that are subject to Consolidated Billing.

Also, we plan to post on our website an additional Medlearn Matters article on therapy services and SNF Consolidated Billing to join the series of Consolidated Billing related articles that already appear there.

Of course, we welcome suggestions from anybody for additional Medlearn Matters articles, and they can be submitted to us at the website shown on the slide.

That basically concludes the PowerPoint presentation part of the session. So without further ado, I'm going to turn things back to Ann Palmer.

MS. PALMER: Operator, would you open up the phone line, please?

As a reminder, please state your name and your organization when you give your call. Thank you.

THE OPERATOR: Thank you.

We will now begin the question-and-answer session.

If you would like to ask a question, please press star-1. Again, please press star-1 if you would like to ask a question. Press star-2 if you would like to withdraw.

Question-and-Answer Session

THE OPERATOR: Sonia McGee, you may ask your question.

MS. McGEE: This is Sonia McGee. I'm from AdminaStar Federal. I had a question regarding the physician services that are available with the 26 modifier. For Method 2, critical access providers, since they are not able to provide claims to the FI with the 26 modifier, how would those come in? Those services would be billed to the FI instead of the carrier with a 096X revenue code.

MS. CARMODY: Hi, Sonia. This is Elizabeth Carmody in the Institutional Billing Group. We don't have anybody with us at the moment who does CAH claims. So, can I get an answer and get back on the next call?

MS. McGEE: That would be fine.

MS. CARMODY: OK.

MS. PALMER: Thank you. Would you get the next

caller on the line, please, Operator?

THE OPERATOR: Cathy Sullivan, you may ask your question.

MS. SULLIVAN: Hi. It is Cathy Sullivan from Rhode Island Medicare Services. I actually just have two questions that come up to our people on the phone line all the time.

Emergency room services are excluded, and I just want to confirm that it is just the emergency room services, that 0450 revenue code, that is excluded, not any of the lab work, EKGs, or anything else that are done. Because the nursing homes continue to tell the providers that any time they are going to the emergency room, all the services being provided at the emergency room are excluded and should be billed to the contractor.

MR. ULLMAN: This is Bill Ullman again. Basically, what gets excluded is the emergency procedure itself and any services that are necessary to complete that procedure. So the classic example is, we are not going to say that emergency surgery is excluded and then not also exclude the anesthesia that you need to do the surgery.

So if there are things that are logically necessary to complete the emergency procedure -- and that would include diagnostic tests that are directly related to figuring out what the emergency condition is -- they also get excluded.

MS. SULLIVAN: So, when you say an emergency procedure, is it only if there is a procedure done, though? What if it is just an emergency room visit?

MR. ULLMAN: Right. Actually, an emergency room visit as well.

MS. SULLIVAN: OK. So, you are saying if there is an emergency room visit on the claim submitted, then everything should be excluded and paid by the contractor, and it shouldn't be billed to the nursing home?

MR. ULLMAN: The things that are clearly related to the emergency, that's true.

MS. CARMODY: Right. And this is Elizabeth Carmody from Institutional Billing. I just want to jump in and say the way that we have defined that relationship in the claims processing system is by the line item date of service.

MS. SULLIVAN: OK. So, if it is all on the

same date of service, then it is all excluded?

MS CARMODY: Yes.

MS. SULLIVAN: Including lab work, x-rays, anything that is done the same day?

MS. CARMODY: For the most part, yes.

MS. SULLIVAN: When you say, I'm sorry, "for the most part" --

MS. CARMODY: I'm trying to think through --

MS. LAMBOWITZ: They had a clinic visit also.

MS. CARMODY: Right. I will say yes. I'm just always worried about the weird case exception that we might have, but, yes.

MS. SULLIVAN: OK. That would be the same thing, then, for an ambulance trip to the hospital where, if it is an emergency room, then the ambulance trip should be covered?

MR. ULLMAN: Then the ambulance trip is also separately billable. What happens there is, the ambulance service is excluded from Consolidated Billing because the receipt of the emergency hospital services has the effect of temporarily suspending the beneficiary's status as a SNF "resident" for Consolidated

Billing purposes. In determining whether or not ambulance services are subject to Consolidated Billing, we generally follow the person's status as the, quote,unquote, "resident" of the SNF.

MS. SULLIVAN: Correct.

MR. ULLMAN: The receipt of these really high-end outpatient hospital services has the effect of temporarily suspending the person's SNF resident status. So this means that not only is the emergency service separately billable, but the ambulance round trip to receive that service is also billable separately.

MS. SULLIVAN: That would include any services rendered by the ambulance, including, for example, an interpretation of an EKG, a tracing that they do, which is allowed to be done in Rhode Island?

MS CARMODY: Anything that is included within the scope of the Part B ambulance benefit.

MS. SULLIVAN: OK. So, if we are having any issues with CWF suspending it, this would be something where we file a problem report with CWF?

MS CARMODY: Yes.

MS. SULLIVAN: Thank you very much.

MS. PALMER: Thank you.

Go ahead, Operator.

THE OPERATOR: Don Facciolo, you may ask your question.

MR. FACCIOLO: Yes, this is Don Facciolo with HCS Administrators. We have three comments and questions.

Slide 11 talks about PT, OT, and SLP services, as does slide 18, and it states that the therapy services are included even when performed by a physician. I would like to point out that you have several exceptions to that rule based on individual procedure codes. When those codes are done by a therapist, they are considered therapy. When they are done by a physician, they are not. I think that needs to be clarified. It has caused some confusion.

Slide 11 talks about lab and x-ray services. The lab services, if they are related to ESRD, are not subject to Consolidated Billing.

Additionally, one of the most problematic issues that we have is in slide 15, and that is the services that should only be done in a hospital or

critical access hospital. I think there is a lot of confusion in the provider community. Right now there are not any edits in place to control that situation. Those services will be paid under SNF Consolidated Billing in places other than hospital and community access hospital.

MR. ULLMAN: This is Bill Ullman again. Addressing that last point first, again, the rationale behind the exclusion of the exceptionally intensive outpatient hospital services was that these are things that really require the intensity of a hospital setting in order to be furnished effectively and safely.

MR. FACCIOLO: Right, Bill. We agree with you. I guess in a lot of rural areas and so on, the physicians and SNFs haven't gotten that word. I think that is something we really need to emphasize. I don't think they ever really are going to get that word, unless those claims are denied. Right now there isn't a mechanism to deny those services performed in other places of service.

MS. LAMBOWITZ: We understand that there is a problem, particularly in rural areas, where the hospitals may not provide these services. The only entity providing service may be a freestanding imaging facility.

The problem is that legislatively we do not have the discretion within CMS to extend the Consolidated Billing exclusion to freestanding entities. We have precedents that talk about the difference between SNF and hospital services, and we were able to use that to look at the intensity of service and the idea that temporarily the person may be a hospital patient.

We don't have the discretion or the authority under the law to extend that to freestanding facilities. That is going to take a legislative change.

MR. FACCIOLO: Right. While I agree with you 100 percent, what I'm trying to bring to your attention is, you are currently paying these services when performed in a freestanding facility or physician's office. I think you want to stop that.

MS. LAMBOWITZ: Our edits are supposed to be catching these, and if you think they are not, we would like to talk to you offline --

MR. FACCIOLO: Sure.

MS. LAMBOWITZ: -- to find out why these are going through. Because the edits are designed to identify and deny these.

MR. ULLMAN: Actually, most of the complaints that we have been getting up to now are from the reverse situation, people who are trying to get these things paid in the freestanding settings without success.

MR. FACCIOLO: Leslie, I know you and I have talked about this several times when the CRs were developed with the CWF edits, and it is a point that I have continually raised. I know these services are paid.

MS. LAMBOWITZ: What we will really need -- and we do want to talk to you further on this -- is some specific examples that we can track and see what is happening with the edits.

MR. FACCIOLO: The edits aren't place of service specific.

MS. TRAZZI: You're breaking up.

MS. PALMER: Operator? Operator?

THE OPERATOR: This is Pam.

MS. PALMER: We are having a lot of difficulty hearing. Would you be able to turn up the volume, please?

THE OPERATOR: One moment.

MS. PALMER: Just, could I ask also the callers

to speak as loudly as they can? Thank you.

MR. FACCIOLO: I'm afraid to talk any louder. I will feel like I'm yelling at you. Is this a little better?

MR. ULLMAN: Yes.

MS. PALMER: That is a little better. We are still having a little bit of trouble hearing you.

MR. FACCIOLO: OK. Let me go to my hand-held set. I'm on a headphone.

[Pause.]

MR. FACCIOLO: How's this?

MS. PALMER: Much better.

MR. FACCIOLO: OK. The CWF edits to control this situation aren't place of service-specific. They are procedure code-specific, and they just look and see whether or not the beneficiary is in a Part A stay. There are no special edits that look for a place of service hospital or critical access hospital that says that those codes are only allowed to be paid in those places. You don't have an edit that says, "This code in an office place of service" or "This code in an independent diagnostic testing facility place of

service," and so on. Those edits do not exist.

MS. TRAZZI: But from the physician side, the physician services are going to pay separately anyway.

MR. FACCIOLO: But let's say the physicians are actually performing a lot of the technical component services in their office and they are billing for these things, and they are being paid because there aren't any place of service-specific edits in CWF.

MS. LAMBOWITZ: Can you give us a couple of --

MR. FOSIOLO: I don't have any claim examples. I don't have claim examples for you. You know, I don't do that, but I'm telling you how the edits work.

MS. LAMBOWITZ: OK. Well, we do want to investigate this further, so why don't we do that and we will try to also give you more information on the next call?

MS. TRAZZI: I'm not here next week, but, I mean, Don, we can take this up --

MR. FACCIOLO: Yes.

MS TRAZZI: -- separately.

MR. FACCIOLO: Yes, I think we need to.

MS. TRAZZI: OK. If you can send me an e-mail

with some of your -- you know, if you have any specifics.

MR. FACCIOLO: Yes. I can show you how the edits work. The definition of the edits are very clear in CWF in what they do, and none of them have place of service included in them.

MS. TRAZZI: Yes, yes. No, I know that.

MR. FACCIOLO: That was the hole we were going to address at a later date, but it hasn't been addressed to this point.

MS. TRAZZI: OK.

MS. PALMER: OK. Thank you.

MR. FACCIOLO: Yes.

THE OPERATOR: Barbara Naugle, you may ask your question, please.

MS. CLARK: Hi. This is actually Alicia Clark with Palmetto GBA. We do the Railroad Medicare contract. This is kind of a really simple question. I just really want confirmation of what I am assuming.

If there is a lab code, for instance, that is designated as "professional only," meaning there is no need to put a 26 modifier, that would be excluded, I would assume. Would I find that in the first file?

[Pause.]

MS. CLARK: Are you able to hear me OK?

MS. LAMBOWITZ: Yes. We are thinking about your question.

MS. CLARK: Oh, I'm sorry.

MS. LAMBOWITZ: You want to know that if there is a lab service that is 100 percent professional component?

MS. CLARK: Right.

MS. TRAZZI: I don't -- you mean, like a diagnostic lab service? We are talking about diagnostic lab services?

MS. CLARK: Clinical diagnostic lab, yes, ma'am.

MS. TRAZZI: I would assume. You would have to give me some codes and I could check the files. That would --

MS. CLARK: OK. I was just thinking for providers that may get confused as to where to look, because typically we look to File number 2 for those professional portions of diagnostic tests that tell them where to go to see if their code is on the list. But I

guess we have run into some -- just a little --

MS. TRAZZI: No. Probably the safest thing is that they just check both lists. I mean, those are both the payable lists, and you know, it takes about two minutes per list to check --

MS. CLARK: True.

MS. TRAZZI: -- to be sure. The first list, I mean, we have on there the things that are fully professional services as well as just, you know, like the chemo drugs that are payable, because those are things that don't need a modifier. Those are on that first list, too.

MS. CLARK: OK.

MS. TRAZZI: So it does contain some other things that we have put on there, just because that is the list that you don't need any kind of a modifier on to get them paid.

MS. CLARK: OK.

MS. TRAZZI: But if you have specific codes, we can check. Just offhand, I don't know of a code that is a diagnostic that is fully professional.

MS. LAMBOWITZ: Right. Yes, I think there has

to be some technical component if a test is being done, we would think.

MS. TRAZZI: I mean, it is a diagnostic lab and it is a PC/TC of zero from the Physician Fee Schedule that says it is a fully physician service, then, yes, it will be on that first file.

MS. CLARK: OK. That is all I was really wanting clarification on.

MS. TRAZZI: If it is a PC/TC zero code.

MS. PALMER: Thank you, Leslie and Sheila.

Go ahead, Operator, please.

THE OPERATOR: Julie Hatesohl, you may ask your question, please.

MS. HATESOHL: Hi. This is Julie Hatesohl calling from Blue Cross and Blue Shield of Kansas. We have had a couple situations come up and it is kind of similar to the gentleman's response earlier.

My understanding is -- and I go by the old information regarding the major categories, the Major Category 1 being services that can only be provided in a critical access hospital. Then you get to a Major Category 3, which is some of your chemotherapy, your

chemotherapy administrations.

Part of the problem that our providers are having is understanding that the chemotherapy is for the chemotherapy services only. We talked earlier about the emergency room services, and I believe the surgeries are the same. We generally use a guideline of going by the same line item dates of service, and those services that are inherent to the surgery or the ER are also excluded.

But when you get into chemotherapy, what my hospital providers are telling me is that there are IV solutions that are administered at the same time as the chemotherapy, there is IV tubing and other supplies that are involved with the administration of the chemotherapy drug, as well as maybe some anti-emetic drugs.

It has become a burden on the hospital side. They basically have to split their claim in half and bill part of it back to the skilled nursing facility, and then they can bill out just the J codes and the administration codes separately. I wanted your comments on that.

MR. ULLMAN: This is Bill Ullman again. I think the treatment of chemotherapy, as far as what gets excluded and what doesn't, is really a direct function of

how Congress wrote that part of the law. It was very specific that what they wanted to carve out was only what they referred to as "high-cost, low-probability" services in that category, nothing else.

So that, anything that is related, like anti-emetics or whatever, is not part of what gets carved out. It is only those specific codes and nothing else. So it really does work a little differently than the ER service.

MS. HATESOHL: OK. And then I had another question or another issue that comes up. You mentioned throughout your slides about noncovered Part A stays, but then we also have situations where the patient doesn't have any benefits. They have exhausted their 100 SNF days.

Does Consolidated Billing apply to that? And how does that work for -- basically, it is not a noncovered Part A stay because they need the skilled services, but they just don't have any days left or they are not eligible.

MR. ULLMAN: Yes. Basically, in any situation where Part A is not in the picture, for whatever reason

-- whether they didn't qualify for it initially because they didn't have a three-day hospital stay, or if they have just used up their Part A benefits -- then what you are looking at is the Part B aspect of Consolidated Billing, which applies only to the three therapies: physical, occupational, and speech-language.

MS. HATESOHL: OK. Thank you.

THE OPERATOR: Brenda Bedard, you may ask your question, please.

MS. BEDARD: Hi. This is Brenda Bedard from the NHIC Medicare Part B carrier. My question is around the agreement or contract between the SNF and the outside entity. What we hear from most of our providers is the SNF is not aware or willing to come up with a written agreement with these outside entities, and, therefore, they are having trouble getting reimbursed for their services. Is there any advice you can give us to tell these providers on what to do to come up with an arrangement with the SNF's?

MR. ULLMAN: Well, again, this is Bill Ullman. We think that this is not only a matter of what Medicare requires but it is really a matter of good business

practice. When you do business with any facility, a SNF or whomever, it is a good idea to have a written agreement in place.

Basically, for any service that is subject to Consolidated Billing that a SNF doesn't furnish itself, the SNF is required by law to have a valid arrangement with the outside supplier that it gets the service from. That means, basically, that the SNF is the one that does the Medicare billing, and then the SNF has to be willing to pay the supplier from that. If they are not willing to pay the supplier, then they are basically not in compliance with the requirement to have an arrangement in place.

So, I guess, you know, that if there is a particularly reluctant SNF, then maybe the supplier might want to check with the servicing Regional Office to try and get them involved in working things out.

MS. BEDARD: OK. Thank you.

MS. LAMBOWITZ: This is Sheila Lambowitz. I did want to just add a couple of things.

We are in the process of revising Transmittal 183 to provide a little more information on under-

arrangements and the whole issue of written contracts. As Bill said, we do think that that is the safest way for any supplier to proceed.

It is nice to know if you are going to provide a service that you are going to get paid. It is sort of important to most people to know how much you are going to get paid. We have facilities that are claiming that they are going out and providing these services without any assurance of when they are going to get paid or how much. As Bill said, we think this is not exactly optimal business practice.

We also have found some situations where the issue is that the SNF wants to pay less than the fee schedule amount.

MS. BEDARD: Right.

MS. LAMBOWITZ: And they are willing to offer a contract but the supplier doesn't like the terms. Now, the supplier, if it doesn't dislike the terms enough to stop providing the service, they just may try to see if they can sneak their bills in through Part B and get the higher payment.

So there is a little bit of a problem on all

sides, and while we are recommending, certainly, that you have a written contract, when there are disputes, there are situations where an agreement does not necessarily have to be in writing, and you know, there are some examples that we are working on now. If we have a specialty physician who sees a SNF patient once, you know, and is not a regular consultant to that nursing facility, there may not be anything formal in writing.

MS. BEDARD: I think that is another issue.

MS. LAMBOWITZ: We have to recognize that.

In the same way, if we have a hospital-based SNF, it may not be required for the SNF to have a written agreement with the hospital lab to do the laboratory work. Since it is one legal entity, you know, their arrangement may not need to be contractual in the same way as you would say have a contract with a therapy company or a contract with a laboratory.

So we are working on this, and we are going to try to get more guidance out.

MS. BEDARD: OK, good, because that is another issue. I think most SNFs are under the impression that an agreement is not mandatory. It is recommended but not

necessary.

MS. LAMBOWITZ: Well, what is actually required is that they pay.

MS. BEDARD: Right.

MS. LAMBOWITZ: That is the point we are trying to get through to everybody. Bill, do you agree?

MR. ULLMAN: Yes.

MS. BEDARD: But they must have an agreement, right, or an arrangement? It's not --

MS. LAMBOWITZ: They have to have --

MS. BEDARD: They can pick and choose.

MS. LAMBOWITZ: -- they are responsible for making the payment. I think that is the issue we are really going to be stressing. We don't care whether they have a 400-page agreement or they have something written on a napkin, but they have to be paying for the services. That is the Medicare requirement.

MS. BEDARD: Thank you.

MS. PALMER: Thank you. Go ahead.

THE OPERATOR: Doreen Talbott, you may ask your question, please.

MS. HOLLY: Hi. This is Elaine Holly from Blue

Cross Blue Shield of Montana. You did address part of a question where the SNF was paying the provider less than the physician fee schedule, but what about if the SNF is reimbursing the provider his billed amount which is higher than Medicare's Physician Fee Schedule? Is that physician required to refund the money because he is being in assignment violation?

MR. ULLMAN: Again, this is Bill Ullman. When we are talking about a situation where there is an arrangement between the SNF and the outside entity, the Medicare transaction is the one where Part A makes the global per diem payment to the SNF. When the SNF pays the outside supplier under the arrangement, that is basically a private transaction between those two parties.

So assignment isn't really part of that because we are not talking about a Medicare transaction. It is really up to those two parties to negotiate the rate that the outside supplier gets paid.

MS. HOLLY: OK. Thank you.

MS. PALMER: Thank you.

THE OPERATOR: Carol Evans, you may ask your

question.

MS. EVANS: I tried to retract that.

THE OPERATOR: You have no question, Carol?

MS. EVANS: That's correct.

THE OPERATOR: Thank you.

Gerard Donovan, you may ask your question.

MR. DONOVAN: Hi. This is Gerard Donovan of Associated Hospital Service, and my question just goes back to the emergency room services.

One of the big issues that has been brought to our attention has been emergency room services that span two days. We are having a problem getting the services on the second day paid. I was just wondering if there is any resolution to that.

MR. ULLMAN: This is Bill Ullman again. My understanding is that the instructions that exist on that basically instruct the hospital to bill all the services as of the first day, the day the person shows up with the emergency condition. That way, the system doesn't have any problems resulting from the services spanning the midnight between the two days.

MR. DONOVAN: Do you know if anything has come

out in writing on that?

MS. CARMODY: We can certainly check that. This is Elizabeth Carmody in Institutional Billing.

But I wanted to ask you a follow-up question in turn. What are the services that are spanning more than one day of the emergency service? Are these observation services?

MR. DONOVAN: It might just be a situation where the person comes in like quarter of 12, and by the time they are out of the emergency room, it is 12:30, 1:00. They might have some lab tests spill over to that next day. So it is really just a timing issue, more or less.

MS. CARMODY: It is a 24-hour day, but it is a date problem.

MR. DONOVAN: Right, exactly.

MS. CARMODY: I got you.

MS. PALMER: Thank you.

MR. DONOVAN: Thank you.

THE OPERATOR: Sonia McGee, you may ask your question, please.

MS. McGEE: Yes, this is Sonia McGee with

AdminaStar Federal again. I just would like some clarification on the Consolidated Billing exclusion for rural health clinics. If it is a hospital-based rural health clinic, the professional or the physician services of the RHC would be considered excluded. However, the technical portions that would normally be billed by the hospital would need to be billed back to the SNF, is that correct?

MS. CARMODY: I think, yes. Sorry. I was making arrangements to answer this at the end of your question. This is Elizabeth Carmody in Institutional Billing.

It is really going to depend on what type of bill the service is coming in on.

MS. McGEE: OK.

MS. CARMODY: If the service is coming in on an RHC or FQHC type of bill, which are types of bills 71X or 73X, those claims are not going to be subject to Consolidated Billing.

MS. McGEE: OK. Services that are the technical components that get billed by the hospital, then those would be billed back to the SNF, correct?

MS. CARMODY: Yes.

MS. McGEE: OK.

MS. PALMER: Thank you.

THE OPERATOR: Pat Sutland [ph], you may ask your question, please.

MS. SUTLAND: Yes. My question was just answered. It was the ER visit that extends into the second calendar date.

MS. PALMER: Operator, can you get the next --

THE OPERATOR: Don Facciolo, you may ask your question, please.

MR. FACCIOLO: Yes, this is Don Facciolo with HGSA. Just following up on the comments earlier regarding the chemotherapy.

I understand that they are supposed to fund the legislation. I was just hoping that possibly CMS could do an educational article in the not too distant future expanding on that and fully explaining it to the provider community. It seems like one of the largest volumes of complaints we get and the individuals who are the most adamant in their complaints are those that are providing chemotherapy services that end up not to be covered.

Additionally, they are asking for some type of a contact or way to potentially expedite the review and consideration of new drugs that have not yet been assigned J codes.

Thank you.

MR. ULLMAN: Thanks. This is Bill Ullman, and thanks for the suggestion about the article. We will look into that.

MS. LAMBOWITZ: And we will talk to the people who do our coding and see if there is a contact to expedite the review of new codes. That is something that is outside of our scope, you know, in terms of Consolidated Billing, but we will see if we can get a contact.

MR. FACCIOLO: Thank you.

MS. PALMER: Thank you.

THE OPERATOR: Gail Franks, you may ask your question, please.

MS. FRANKS: Yes, ma'am. On page 14 of the PowerPoint, the last bullet where it says, "Hospice care related to a beneficiary's terminal care." Is that all-inclusive? Because, normally, specifically for ambulance

transport, if they have not yet been admitted or have just recently been discharged from a hospice situation, then ambulance would be able to bill it separately.

MR. ULLMAN: This is Bill Ullman again. I'm not sure if I totally understand the scenario. Is this somebody who has revoked their hospice election? Is that what we are referring to?

MS. FRANKS: That is what we normally -- if they have revoked it, then ambulance would be able to bill separately.

MR. ULLMAN: OK. Well, I would think that in a situation where they have revoked the hospice election, then the hospice exclusion wouldn't come into play. You basically have a situation that would be the same as any other SNF resident and the normal rules regarding ambulance would apply, which means that it is basically bundled in any situation that the person is considered a SNF resident, other than getting dialysis services off-site, which are always separately billable.

MS. FRANKS: OK. I have one other question, if you don't mind. We are currently having issues with our providers correctly identifying SNF facilities versus

nursing home level beds. Is there going to be a way that they can readily identify that?

MR. ULLMAN: You are referring to a situation where the nursing home has a distinct part that is certified as a Medicare SNF and the rest of the building is non-certified?

MS. FRANKS: Yes, sir.

MR. ULLMAN: OK. Basically, it would seem that they would have to have some way of distinguishing, because that would really determine whether the person can get Part A SNF coverage to begin with.

MS. CARMODY: This is Elizabeth Carmody in Institutional Billing. Can you tell us what types of providers are having this problem identifying this?

MS. FRANKS: Specifically ambulance. I mean, I'm dealing with validation of the modifiers, because it is a different modifier for nursing homes versus like an extended care facility, or even a SNF that is inside a hospital even would be a different modifier.

MS. PALMER: Caller, would you please state your name and organization?

MS. FRANKS: Ma'am?

MS. PALMER: Would you please state your name and your organization?

MS. FRANKS: This is Cahaba GBA in Jackson, Mississippi. My name is Gail Franks.

MS. PALMER: Thank you.

MS. FRANKS: You're welcome.

MS. LAMBOWITZ: I think, judging from the faces around here, we are going to have to research this, and hopefully we will be able to get you an answer at the next call.

MS. FRANKS: OK. Thank you.

MS. PALMER: Thank you, Sheila.

Go ahead, Operator, please.

THE OPERATOR: Susan Pennington, you may ask your question, please.

MS. PENNINGTON: Hi. This is Sue Pennington from Region VII. Back to a previous discussion where you were talking about, you know, the SNF is responsible for paying these other providers for things that are included in the Consolidated Billing, if they are refusing to do that either because they say, "We don't have a contract with you or an arrangement with you," or whatever, what

is the recourse for that provider, other than like to report it to Survey and Cert as a complaint?

I mean, how can they get their money if the SNF is just saying, "No, we never had a contract with you. We are not going to pay for this"?

MS. LAMBOWITZ: We are working on that issue, and I hope we will have an answer next week.

MS. PENNINGTON: OK. Thank you.

MS. PALMER: Thank you, Sheila.

THE OPERATOR: Pat Zachmann, you may ask your question.

MS. ZACHMANN: Thanks. I have a question on customized devices.

MS. PALMER: I'm sorry. Can you speak up? We can't hear you.

MS. ZACKMANN: OK. Can you hear me now?

MS. PALMER: Yes.

MS. ZACKMANN: Better? OK.

I have a question on customized devices. When they are ordered while the patient is an inpatient in the acute hospital but delivered after the patient is already in the SNF, and also -- the other scenario from the same

provider -- they are at home when the device is ordered but in the SNF already once it is delivered. Who is responsible for doing the billing for both of those situations?

MR. ULLMAN: This is Bill Ullman again. My understanding of the way coverage works for those kinds of things is that coverage attaches to the item at the point where it is, quote, unquote, "delivered for use" by the beneficiary. So if it is actually delivered for use when they are in the SNF, then the SNF rules would apply. If it is one of the excluded codes for a customized prosthetic device, then it is separately billable under Part B.

MS. ZACHMANN: OK. So there wouldn't be a different answer if that patient was in the hospital or if they were in fact at home when the device was actually ordered?

MR. ULLMAN: I'm getting some discussion from the other end of the table here, so I think we might want to discuss this one a little further before we make a definitive answer.

MS. ZACHMANN: OK.

MS. PALMER: Caller, could you state your name and organization, please?

MS. ZACHMANN: I'm sorry. My name is Pat Zachmann, and I'm from United Government Services.

MS. PALMER: Thank you.

Can we have the next caller, please?

THE OPERATOR: At this time, Ms. Palmer, we have no more questions.

MS. PALMER: OK, then. Thank you.

We are going to be having our second conference call next week, on Thursday, October the 14th, at 2:30 Eastern time. The call in phone number will be 1-888-455-9641.

Thank you very much for your participation.

MS. LAMBOWITZ: Excuse me. Before you leave -- this is Sheila Lambowitz -- next week we are going to try to have a brief discussion on overpayments and the activities we are taking to recoup money when we have identified both supplier and SNF bills during the same time period. So this may be of interest to staff in your overpayment departments.

Sorry, and thank you. I guess I forgot to

mention that to Ann, but I just wanted to let you know before we ended the call.

Anyway, thank you very much.

MS. PALMER: Thank you.

[Whereupon, the conference call was concluded.]

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