



# Federal Register

---

**Tuesday,  
May 12, 2009**

---

## **Part II**

# **Department of Health and Human Services**

---

**Centers for Medicare & Medicaid Services**

---

**42 CFR Part 483**

**Medicare Program; Prospective Payment  
System and Consolidated Billing for  
Skilled Nursing Facilities for FY 2010;  
Minimum Data Set, Version 3.0 for  
Skilled Nursing Facilities and Medicaid  
Nursing Facilities; Proposed Rule**

available FY for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this proposed rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2008 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the proposed payment rates for FY 2010 do not include a forecast error adjustment.

### C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2010 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2008 through September 30, 2009 to the average market basket level for the period of October 1, 2009 through September 30, 2010. Using this process, the proposed market basket update factor for FY 2010 SNF PPS Federal rates is 2.1 percent. We used this proposed update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

### VII. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places the Medicare billing responsibility for virtually all of the services that the SNF's residents receive with the SNF, except for a small number of services that the statute specifically identifies as being excluded from this provision. As noted previously in section I. of this proposed rule, subsequent legislation enacted a number of modifications in the consolidated billing provision.

Specifically, section 103 of the BBRA amended this provision by further excluding a number of individual "high-cost, low-probability" services, identified by the Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the proposed and final

rules for FY 2001 (65 FR 19231–19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at <http://www.cms.hhs.gov/transmittals/downloads/ab001860.pdf>.

Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare Part A does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater detail in the proposed and final rules for FY 2002 (66 FR 24020–24021, May 10, 2001, and 66 FR 39587–39588, July 31, 2001).

In addition, section 410 of the MMA amended this provision by excluding certain practitioner and other services furnished to SNF residents by RHCs and FQHCs. We discuss this MMA amendment in greater detail in the update notice for FY 2005 (69 FR 45818–45819, July 30, 2004), as well as in Program Transmittal #390 (Change Request #3575), issued December 10, 2004, which is available online at <http://www.cms.hhs.gov/transmittals/downloads/r390cp.pdf>.

Further, while not substantively revising the consolidated billing requirement itself, a related provision was enacted in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275). Specifically, section 149 of MIPPA amended section 1834(m)(4)(C)(iii) of the Act to add subclause (VII), which adds SNFs (as defined in section 1819(a) of the Act) to the list of entities that can serve as a telehealth "originating site" (that is, the location at which an eligible individual can receive, through the use of a telecommunications system, services furnished by a physician or other practitioner who is located elsewhere at a "distant site").

As explained in the Medicare Physician Fee Schedule (PFS) final rule for Calendar Year (CY) 2009 (73 FR 69726, 69879, November 19, 2008), a telehealth originating site receives a facility fee which is always separately payable under Part B outside of any other payment methodology. Section 149(b) of MIPPA amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) of the Act from the definition of "covered skilled

nursing facility services" that are paid under the SNF PPS. Thus, a SNF " \* \* \* can receive separate payment for a telehealth originating site facility fee even in those instances where it also receives a bundled per diem payment under the SNF PPS for a resident's covered Part A stay" (73 FR 69881). By contrast, under section 1834(m)(2)(A) of the Act, a telehealth distant site service is payable under Part B to an eligible physician or practitioner only to the same extent that it would have been so payable if furnished *without* the use of a telecommunications system. Thus, as explained in the CY 2009 PFS final rule, eligible distant site physicians or practitioners can receive payment for a telehealth service that they furnish

\* \* \* only if the service is separately payable under the PFS when furnished in a face-to-face encounter at that location. For example, we pay distant site physicians or practitioners for furnishing services via telehealth only if such services are not included in a bundled payment to the facility that serves as the originating site (73 FR 69880).

This means that in those situations where a SNF serves as the telehealth originating site, the distant site professional services would be separately payable under Part B only to the extent that they are not already included in the SNF PPS bundled per diem payment and subject to consolidated billing. Thus, for a type of practitioner whose services are not otherwise excluded from consolidated billing when furnished during a face-to-face encounter, the use of a telehealth distant site would not serve to unbundle those services. In fact, consolidated billing does exclude the professional services of physicians, along with those of most of the other types of telehealth practitioners that the law specifies at section 1842(b)(18)(C) of the Act, that is, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and clinical psychologists (see section 1888(e)(2)(A)(ii) of the Act and 42 CFR 411.15(p)(2)). However, the services of clinical social workers, registered dietitians and nutrition professionals remain subject to consolidated billing when furnished to a SNF's Part A resident and, thus, cannot qualify for separate Part B payment as telehealth distant site services in this situation. Additional information on this provision appears in Program Transmittal #1635 (Change Request #6215), issued November 14, 2008, which is available online at <http://www.cms.hhs.gov/transmittals/downloads/R1635CP.pdf>.