Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

Legislative History

Updated: January 26, 2021

Historically, each rule or update notice issued under the annual Skilled Nursing Facility (SNF) prospective payment system (PPS) rulemaking cycle included a detailed reiteration of the various individual legislative provisions that have affected the SNF PPS over the years, a number of which represented temporary measures that have long since expired. This document now serves to provide that discussion.

I. Legislative History of the SNF Prospective Payment System (PPS)

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105-33, enacted on August 5, 1997) amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. Major elements of the SNF PPS include:

- Rates. As explained in the May 12, 1998 interim final rule (63 FR 26252, available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf), we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included a "Part B add-on" (an estimate of the cost of those services that, before July 1, 1998, were paid under Part B, but furnished to Medicare beneficiaries in a SNF during a Part A covered stay). We adjust the rates annually using a SNF market basket index to reflect changes in the costs of goods and services used to provide SNF care, and we also adjust the rates by the hospital inpatient wage index to account for geographic variation in wages. As described in Section I.F, effective FY 2012, we include an annual multifactor productivity adjustment to ensure that the annual market basket update also accounts for increases in provider productivity. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. Originally, this adjustment involved the 44-group Resource Utilization Groups, version 3 (RUG-III) case-mix classification system, using information obtained from the required resident assessments under version 2.0 of the Minimum Data Set (MDS 2.0). As of FY 2011, this adjustment converted to the 66-group version 4 of the RUG model (RUG-IV), as well as version 3.0 of the MDS (MDS 3.0). As of FY 2020, this adjustment utilizes the Patient Driven Payment Model (PDPM). Additionally, the payment rates at various times have also reflected specific legislative provisions for certain temporary adjustments, as discussed in the following sections of this document.

- Transition. Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base

payments entirely on the adjusted Federal per diem rates, the SNF PPS no longer utilizes adjustment factors related to facility-specific rates.

- Coverage. The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption under which the assignment of one of the designated, more intensive case-mix classifiers on the initial five-day Medicare-required assessment serves to assist in making certain SNF level of care determinations. In the July 30, 1999 final rule (64 FR 41670, available online at www.gpo.gov/fdsys/pkg/FR-1999-07- 30/pdf/99-19478.pdf), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure.

- Consolidated Billing. The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills to its fiscal intermediary or Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, this provision places with the SNF the Medicare billing responsibility for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a non-covered stay. The statute excludes a small list of services from the consolidated billing provision (primarily those of physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. A more detailed discussion of this provision appears in Section II of this document and on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html.

- Payment for SNF-Level Swing-Bed Services. Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002.

- Availability of Wage Index Values. For a number of years, the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas were published in the **Federal Register** as Tables A and B, respectively, in an Addendum to the annual SNF PPS rulemaking (that is, the SNF PPS proposed and final rules or, when applicable, the current update notice). However, as of FY 2012, a number of other Medicare payment systems adopted an approach in which such tables were no longer published in the **Federal Register** in this manner, and instead have been made available exclusively through the Internet; see, for example, the FY 2012 Hospital Inpatient PPS (IPPS) final rule (76 FR 51476, August 18, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf). To be consistent with these other Medicare payment systems and streamline the published content to focus on policy discussion, we have adopted a similar approach for the SNF PPS as well. Under this approach, effective October 1, 2013, the individual wage index values formerly displayed as Tables A and B in the annual SNF PPS rulemaking are instead made available exclusively through the Internet on CMS's SNF PPS website at www.cms.gov/Medicare/Medicare-Fee-

for-Service-Payment/SNFPPS/WageIndex.html. Consistent with the provisions of section 1888(e)(4)(H)(iii) of the Act, we continue to publish in the **Federal Register** the specific "factors to be applied in making the area wage adjustment" (for example, the SNF prospective payment system's methodological use of the hospital wage index exclusive of its occupational mix adjustment) as part of our annual SNF PPS rulemaking process, but that document no longer includes a listing of the individual wage index values themselves, which instead are made available exclusively through the Internet on the CMS website.

B. Requirements of the Balanced Budget Act of 1997 (BBA) for Updating the Prospective Payment System for Skilled Nursing Facilities

As added by section 4432(a) of the BBA, section 1888(e)(4)(H) of the Act requires that we provide for publication annually in the **Federal Register**:

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
2. The case-mix classification system to be applied with respect to these services during the upcoming FY.
3. The factors to be applied in making the area wage adjustment with respect to these services.

C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)

There were several provisions in the BBRA (Pub. L. 106-113, Appendix F, enacted on November 29, 1999) that resulted in adjustments to the SNF PPS. We described these provisions in detail in the FY 2001 SNF PPS final rule (65 FR 46770, July 31, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-07-31/pdf/00-19004.pdf). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified groups in the original, 44-group RUG-III case-mix classification system. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, upon the implementation of a refined, 53-group version of the RUG-III system, RUG-53. We included further information on BBRA provisions that affected the SNF PPS in Program Memoranda A-99-53 and A-99-61 (December 1999).

Also, section 103 of the BBRA designated certain additional services for exclusion from the consolidated billing requirement, as discussed in Section II of this document. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the FY 2002 final rule (66 FR 39562, July 31, 2001, available

online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf), we made conforming changes to the regulations at §413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

The BIPA (Pub. L. 106-554, Appendix F, enacted December 21, 2000) also included several provisions that resulted in adjustments to the SNF PPS. We described these provisions in detail in the FY 2002 final rule (66 FR 39562, July 31, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf)). In particular:

- Section 203 of the BIPA exempted CAH swing beds from the SNF PPS. We included further information on this provision in Program Memorandum A-01-09 (Change Request #1509), issued January 16, 2001, which is available online at www.cms.gov/transmittals/downloads/a0109.pdf.

- Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at www.cms.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.

- Section 312 of the BIPA provided for a temporary increase of 16.66 percent in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002; accordingly, this add-on is no longer in effect. This section also directed the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. The report (GAO-03-176), which GAO issued in November 2002, is available online at www.gao.gov/new.items/d03176.pdf.

- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical therapy, occupational therapy, and speech-language pathology services) furnished to SNF residents during non-covered stays, effective January 1, 2001. (A more detailed discussion of this provision appears in Section II of this document.)

- Section 314 of the BIPA corrected an anomaly involving three of the RUGs that section 101(a) of the BBRA had designated to receive the temporary payment adjustment discussed above in section I.C. of this document. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)

- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

We included further information on several of the BIPA provisions in Program Memorandum A-01-08 (Change Request #1510), issued January 16, 2001, which is available online at www.cms.gov/transmittals/downloads/a0108.pdf.

E. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

The MMA (Pub. L. 108-173, enacted on December 8, 2003) included a provision that resulted in a further adjustment to the SNF PPS. Specifically, section 511 of the MMA amended section 1888(e)(12) of the Act, to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until ". . . the Secretary certifies that there is an appropriate adjustment in the case mix . . . to compensate for the increased costs associated with [such] residents . . . ." The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.gov/transmittals/downloads/r160cp.pdf. In the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), we did not address the certification of the AIDS add-on in that final rule's implementation of the case-mix refinements for RUG-IV, thus allowing the temporary add-on payment created by section 511 of the MMA to remain in effect for the time being.

Implementation of this provision resulted in a significant increase in payment, but only for the limited number of SNF residents that actually qualified for the AIDS add-on. For example, using FY 2011 data, we identified less than 4,100 SNF residents with a diagnosis of Human Immunodeficiency Virus (HIV) Infection. As the PDPM case-mix classification model was being developed, its rate components were designed with specific consideration of the need to account accurately for the increased costs associated with caring for SNF patients with AIDS. Accordingly, the FY 2019 SNF PPS final rule certified ". . . that there is an appropriate adjustment in the PDPM to compensate for the increased costs associated with residents with AIDS" and, thus, provided that the MMA's temporary AIDS add-on would be replaced ". . . with the PDPM's permanent adjustment in the case mix that appropriately accounts for the increased costs of patients with AIDS, effective with the conversion to the PDPM on October 1, 2019" (83 FR 39255, August 8, 2018).

In addition, section 410 of the MMA contained a provision that excluded from consolidated billing certain services furnished to SNF residents by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs). (Further information on this provision appears in section II of this document.)

F. The Affordable Care Act

On March 23, 2010, the Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted. Then, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) amended certain provisions of Pub. L. 111-148 and certain sections of the statute and, in certain instances, included "freestanding" provisions (Pub. L. 111-148 and Pub. L. 111-152 are collectively referred to here as the "Affordable Care Act").

Effective FY 2012, section 3401(b) of the Affordable Care Act requires that the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the

Social Security Act (the Act) is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. As explained in the Senate Finance Committee report that accompanied S.1796 ("America's Healthy Future Act of 2009," the Senate's initial version of the health care reform legislation that ultimately was enacted in Pub. L. 111-148), the purpose of this type of productivity adjustment is to help ensure that the market basket update, in accounting for changes in the costs of goods and services used to provide patient care, also reflects ". . . increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, etc.)" (S. Rep. No. 111-89 at 261). Specifically, section 3401(a) of the Affordable Care Act amends section 1886(b)(3)(B) of the Act to add clause (xi)(II), which sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the "MFP adjustment"). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. Please see www.bls.gov/mfp to obtain the BLS historical published MFP data.

Section 10325 of the Affordable Care Act included an additional provision involving the SNF PPS. That provision postponed the implementation of the RUG-IV case-mix classification system published in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), requiring that the Secretary not implement the RUG-IV case-mix classification system before October 1, 2011. Notwithstanding this postponement of overall RUG-IV implementation, section 10325 of the Affordable Care Act further specified that the Secretary implement, effective October 1 2010, the changes related to concurrent therapy and the look-back period that were finalized as components of RUG-IV (see 74 FR 40315-19, 40322-24, August 11, 2009). As we noted in the FY 2011 SNF PPS notice with comment period (75 FR 42889, July 22, 2010, available online at www.gpo.gov/fdsys/pkg/FR-2010-07-22/pdf/2010-17628.pdf), implementing the particular combination of RUG-III and RUG-IV features specified in section 10325 of the Affordable Care Act would require developing a revised grouper, something that could not be accomplished by that provision's effective date (October 1, 2010) without risking serious disruption to providers, suppliers, and State agencies. Accordingly, in the FY 2011 notice with comment period, we announced our intention to proceed on an interim basis with implementation of the full RUG-IV case-mix classification system as of October 1, 2010, followed by a retroactive claims adjustment, using a hybrid RUG-III (HR-III) system reflecting the Affordable Care Act configuration, once we had developed a revised grouper that could accommodate it.

However, section 202 of the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309, enacted on December 15, 2010) subsequently repealed section 10325 of the Affordable Care Act. We therefore left in place the implementation of the full RUG-IV system as of FY 2011, as finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf). In addition, we note that implementation of version 3.0 of the Minimum Data Set (MDS 3.0) proceeded as originally scheduled, with an effective date of October 1, 2010. The MDS 3.0 RAI Manual and MDS 3.0 Item Set are published on the MDS 3.0 Training Materials Web site, at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Accordingly, as discussed above, effective October 1, 2010, we implemented and began paying claims under the RUG-IV system that was finalized in the FY 2010 SNF PPS final rule.

We note that a parity adjustment was applied to the RUG-53 nursing case-mix weights when the RUG-III system was initially refined in 2006, in order to ensure that the implementation of the refinements would not cause any change in overall payment levels (70 FR 45031, August 4, 2005, available online at www.gpo.gov/fdsys/pkg/FR-2005-08-04/pdf/05-15221.pdf). Similarly, a parity adjustment was applied to the RUG-IV nursing case-mix weights for FY 2011 when the new classification system was implemented. A detailed discussion of the parity adjustment in the specific context of the RUG-IV payment rates appears in the FY 2010 SNF PPS proposed rule (74 FR 22236-38, May 12, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-05-12/pdf/E9-10461.pdf) and final rule (74 FR 40338-40339, August 11, 2009, available online at www.gpo.gov/fdsys/pkg/FR-2009-08-11/pdf/E9-18662.pdf), and in the FY 2011 notice with comment period (75 FR 42892-42893, July 22, 2010, available online at www.gpo.gov/fdsys/pkg/FR-2010-07-22/pdf/2010-17628.pdf).

For FY 2012, the RUG-IV parity adjustment was recalibrated in order to restore the intended parity in overall payments between the RUG-IV and RUG-53 case mix classification systems, as discussed in the FY 2012 SNF PPS proposed rule (76 FR 26370-26373, May 6, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10555.pdf) and final rule (76 FR 48492-48500, 48537-48538 August 8, 2011, available online at www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf).

G. Protecting Access to Medicare Act (PAMA)

On April 1, 2014, the Protecting Access to Medicare Act (PAMA, Pub. L. 113-93) was enacted.

- Section 215(a) of PAMA added a new subsection (g) to section 1888 of the Social Security Act requiring the Secretary to specify certain quality measures for the skilled nursing facility setting.

- Additionally, section 215(b) of PAMA added a new subsection (h) to section 1888 of the Social Security Act requiring the Secretary to implement a value-based purchasing program for skilled nursing facilities.

H. Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, Pub. L. 113-185) was enacted.

- Section 2(c)(4) of the IMPACT Act added a new subsection (e)(6) to section 1888 of the Social Security Act requiring the Secretary to implement a quality reporting program for SNFs under which SNFs report data on measures and resident assessment data.

II. Legislative History of SNF Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, 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 document, 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 Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the FY 2001 proposed and final rules (65 FR 19231 through 19232, April 10, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-04-10/pdf/00-8481.pdf, and 65 FR 46790 through 46795, July 31, 2000, available online at www.gpo.gov/fdsys/pkg/FR-2000-07-31/pdf/00-19004.pdf), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.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 therapy, occupational therapy, and speech-language pathology services 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 FY 2002 proposed and final rules (66 FR 24020 through 24021, May 10, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-05-10/pdf/01-11560.pdf, and 66 FR 39587 through 39588, July 31, 2001, available online at www.gpo.gov/fdsys/pkg/FR-2001-07-31/pdf/01-18869.pdf).

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 FY 2005 update notice (69 FR 45818 through 45819, July 30, 2004, available online at www.gpo.gov/fdsys/pkg/FR-2004-07-30/pdf/04-17443.pdf), as well as in Medicare Learning Network (MLN) Matters article #MM3575, which is available online at www.cms.gov/MLNMattersArticles/downloads/MM3575.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)(ii) 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 a telecommunications system, services of 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, available online at www.gpo.gov/fdsys/pkg/FR-2008-11-19/pdf/E8-26213.pdf), 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 Physician Fee Schedule final rule (73 FR 69726, 69880), 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.

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 MLN Matters article #MM6215, which is available online at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6215.pdf.

Effective for items and services furnished on or after October 1, 2021, §134 in Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) added certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders to the statutory list of excluded service codes that was originally enacted in the BBRA, as discussed above.