CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10639	**Date: March 12, 2021**
	Change Request 11862

SUBJECT: Update to the Manual for Telephone Services, Physician Assistant (PA) Supervision, and Medical Record Documentation for Part B Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify existing manual language. We are revising the manual as well by removing paragraph B. Telephone Services, as CMS makes payment for a short communication-technology based service that can be furnished using any modality of synchronous communication technology that can include audio-only telephone, as of January 1, 2019. We want to bring the manual in line with current payment policy for PA supervision, which was effective as of January 1, 2020 and medical record documentation for Part B services, which was also effective January 1, 2020 and further clarified and effective as of January 1, 2021.

EFFECTIVE DATE: January 1, 2019 - For 100-02 and 100-04; January 1, 2020 - For 100-02 only; January 1, 2021 - For 100-02 only
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 12, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30/Physician Services
R	15/180/Nurse-Midwife (CNM) Services
R	15/190/Physician Assistant (PA) Services
R	15/200/Nurse Practitioner (NP) Services
R	15/210/Clinical Nurse Specialist (CNS) Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 10639	Date: March 12, 2021	Change Request: 11862

SUBJECT: Update to the Manual for Telephone Services, Physician Assistant (PA) Supervision, and Medical Record Documentation for Part B Services

EFFECTIVE DATE: January 1, 2019 - For 100-02 and 100-04; January 1, 2020 - For 100-02 only; January 1, 2021 - For 100-02 only
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 12, 2021

I. GENERAL INFORMATION

A. Background: As of January 1, 2019, CMS makes payment for a short communication-technology based service that can be furnished using any modality of synchronous communication technology that can include audio-only telephone.

CMS finalized for Calendar Year (CY) 2020 the "Physician Supervision for Physician Assistant (PA) Services" proposal implementing our reinterpretation of Medicare law that requires physician supervision for the professional services of PAs. Accordingly, Federal Regulations at 42 CFR 410.74 (a)(2) require that a PA must furnish their professional services in accordance with State law and State scope of practice rules for PAs in the State in which the services are furnished to the extent that those rules describe the required relationship between physicians and PAs, including its collaborative nature, describe a form of supervision for Medicare's purposes. For States with no explicit State law and guidance regarding physician supervisions of PAs, physician supervision is a process with one or more physicians to supervise the delivery of their healthcare services. Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationships the PA has with the supervising physicians when furnishing professional services, with any required documentation of PA supervision maintained at the practice level, instead of in the medical record for each patient.

CMS finalized in the CY 2020 Physician Fee Schedule Final Rule a proposal to reduce burden by implementing a broadened general principle beyond teaching physicians, that allows all physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs) and, Certified Registered Nurse Anesthetists (CRNAs), each of whom are recognized as Advanced Practice Registered Nurses (APRNs), to review and verify (sign/date) documentation in medical records without having to re-document notes already included in the medical record. This principle applies across the spectrum for all Medicare-covered professional services furnished by each of these professionals that are paid under the Medicare Part B Physician Fee Schedule. Also, in addition to physicians, residents, nurses, and medical students, this provision includes PA and APRN students or other members of the medical teams, as those individuals who are allowed to make notes in a patient's medical record that are reviewed and verified by physicians, PA's and APRNs.

CMS further clarified in the CY 2021 Physician Fee Schedule Final Rule that this documentation flexibility also applies to therapists.

B. Policy: This CR updates the Internet Only Manual (IOM) for by removing outdated language by removing the Case Management Services section to reflect that Team Conference codes have been deleted and that audio-only visits can be paid for. In addition, revises language for Physician Supervision for PA Services, and adds language for Review and Verification of Medical Record Documentation.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11862 - 02.1	Contractors shall be aware of the new policies described in this manual update.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11862 - 02.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sarah Leipnik, 410-786-3933 or Sarah.Leipnik@cms.hhs.gov (For PA supervision and medical record documentation.) , Emily Yoder, 410-786-1804 or Emily.Yoder@cms.hhs.gov (For telephone services), Patrick Sartini, 410-786-9252 or Patrick.Sartini@cms.hhs.gov (For telephone services), Regina Walker-Wren, 410-786-9160 or Regina.WalkerWren@cms.hhs.gov (For PA supervision and medical record documentation) , Donta Henson, 410-786-1947 or Donta.Henson1@cms.hhs.gov (For telephone services).

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

30 - Physician Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

A. General

Physician services are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight.

The physician must render the service for the service to be covered. (See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70, for definition of physician.) A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

Professional services of the physician are covered if provided within the United States, and may be performed in a home, office, institution, or at the scene of an accident. A patient's home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative's home.

B. Consultations

As of January 1, 2010, CMS no longer recognizes consultation codes for Medicare payment, except for inpatient telehealth consultation HCPCS G-codes. Instead, physicians and qualified nonphysician practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code. For further detail regarding reporting services that would otherwise be described by the CPT consultation codes (99241-99245 and 99251-99255), see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6. For detailed instructions regarding reporting telehealth consultation services and other telehealth services, see Pub. 100-04, chapter 12, section 190.3.

C. Patient-Initiated Second Opinions

Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

D. Concurrent Care

Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.

In order to determine whether concurrent physicians' services are reasonable and necessary, the A/B MAC (B) must decide the following:

1. Whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis, and

2. Whether the individual services provided by each physician are reasonable and necessary.

In resolving the first question, the A/B MAC (B) should consider the specialties of the physicians as well as the patient's diagnosis, as concurrent care is usually (although not always) initiated because of the existence of more than one medical condition requiring diverse specialized medical or surgical services. The specialties of the physicians are an indication of the necessity for concurrent services, but the patient's condition and the inherent reasonableness and necessity of the services, as determined by the A/B MAC (B)'s medical staff in accordance with locality norms, must also be considered. For example, although cardiology is a sub-specialty of internal medicine, the treatment of both diabetes and of a serious heart condition might require the concurrent services of two physicians, each practicing in internal medicine but specializing in different sub-specialties.

While it would not be highly unusual for concurrent care performed by physicians in different specialties (e.g., a surgeon and an internist) or by physicians in different subspecialties of the same specialty (e.g., an allergist and a cardiologist) to be found medically necessary, the need for such care by physicians in the same specialty or subspecialty (e.g., two internists or two cardiologists) would occur infrequently since in most cases both physicians would possess the skills and knowledge necessary to treat the patient. However, circumstances could arise which would necessitate such care. For example, a patient may require the services of two physicians in the same specialty or sub-specialty when one physician has further limited his or her practice to some unusual aspect of that specialty, e.g., tropical medicine. Similarly, concurrent services provided by a family physician and an internist may or may not be found to be reasonable and necessary, depending on the circumstances of the specific case. If it is determined that the services of one of the physicians are not warranted by the patient's condition, payment may be made only for the other physician's (or physicians') services.

Once it is determined that the patient requires the active services of more than one physician, the individual services must be examined for medical necessity, just as where a single physician provides the care. For example, even if it is determined that the patient requires the concurrent services of both a cardiologist and a surgeon, payment may not be made for any services rendered by either physician which, for that condition, exceed normal frequency or duration unless there are special circumstances requiring the additional care.

The A/B MAC (B) must also assure that the services of one physician do not duplicate those provided by another, e.g., where the family physician visits during the post-operative period primarily as a courtesy to the patient.

Hospital admission services performed by two physicians for the same beneficiary on the same day could represent reasonable and necessary services, provided, as stated above, that the patient's condition necessitates treatment by both physicians. The level of difficulty of the service provided may vary between the physicians, depending on the severity of the complaint each one is treating and that physician's prior contact with the patient. For example, the admission services performed by a physician who has been treating a patient over a period of time for a chronic condition would not be as involved as the services performed by a physician who has had no prior contact with the patient and who has been called in to diagnose and treat a major acute condition.

A/B MACs (B) should have sufficient means for identifying concurrent care situations. A correct coverage determination can be made on a concurrent care case only where the claim is sufficiently documented for the A/B MAC (B) to determine the role each physician played in the patient's care (i.e., the condition or conditions for which the physician treated the patient). If, in any case, the role of each physician involved is not clear, the A/B MAC (B) should request clarification.

E. Completion of Claims Forms

Separate charges for the services of a physician in completing a Form CMS-1500, a statement in lieu of a Form CMS-1500, or an itemized bill are not covered. Payment for completion of the Form CMS-1500 claim form is considered included in the fee schedule amount.

F. Care Plan Oversight Services

Care plan oversight is supervision of patients under care of home health agencies or hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication with other health professionals not employed in the same practice who are involved in the patient's care, integration of new information into the care plan, and/or adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for patients of skilled nursing facilities (SNFs), nursing home facilities, or hospitals.

These services are covered only if all the following requirements are met:

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;

2. The care plan oversight (CPO) services should be furnished during the period in which the beneficiary was receiving Medicare covered HHA or hospice services;

3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;

4. The physician furnished at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician's nurse or the time spent consulting with one's nurse is not countable toward the 30-minute threshold. Low-intensity services included as part of other evaluation and management services are not included as part of the 30 minutes required for coverage;

5. The work included in hospital discharge day management (codes 99238-99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital;

6. The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the first care plan oversight service. Only evaluation and management services are acceptable prerequisite face-to-face encounters for CPO. EKG, lab, and surgical services are not sufficient face-to-face services for CPO;

7. The care plan oversight billed by the physician was not routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;

8. If the beneficiary is receiving home health agency services, the physician did not have a significant financial or contractual interest in the home health agency. A physician who is an employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice;

9. The physician who bills the care plan oversight services is the physician who furnished them;

10. Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement;

11. The physician is not billing for the Medicare end stage renal disease (ESRD) capitation payment for the same beneficiary during the same month; and

12. The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.

G. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B covered services, the certified nurse-midwife, nurse practitioner, physician assistant, clinical nurse specialist, and any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team, including as applicable, notes documenting the physician or nonphysician practitioner's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

180 - Nurse-Midwife (CNM) Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

A. General

Effective on or after July 1, 1988, the services provided by a certified nurse-midwife or incident to the certified nurse-midwife's services are covered. Payment is made under assignment only.

See the Medicare Claims Processing Manual, Chapter 12, "Physician and Nonphysician Practitioners," §130, for payment methodology for nurse midwife services.

B. Certified Nurse-Midwife Defined

A certified nurse-midwife is a registered nurse who has successfully completed a program of study and clinical experience in nurse-midwifery, meeting guidelines prescribed by the Secretary, or who has been certified by an organization recognized by the Secretary. The Secretary has recognized certification by the American College of Nurse-Midwives and State qualifying requirements in those States that specify a program of education and clinical experience for nurse-midwives for these purposes. A nurse-midwife must:

- Be currently licensed to practice in the State as a registered professional nurse; and

- Meet one of the following requirements:

    1. Be legally authorized under State law or regulations to practice as a nurse-midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the State; or

    2. If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, the nurse-midwife must:

a. Be currently certified as a nurse-midwife by the American College of Nurse-Midwives;

b. Have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or

c. Have successfully completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.

C. Covered Services

1. General - Effective January 1, 1988, through December 31, 1993, the coverage of nurse-midwife services was restricted to the maternity cycle. The maternity cycle is a period that includes pregnancy, labor, and the immediate postpartum period.

Beginning with services furnished on or after January 1, 1994, coverage is no longer limited to the maternity cycle. Coverage is available for services furnished by a nurse-midwife that he or she is legally authorized to perform in the State in which the services are furnished and that would otherwise be covered if furnished by a physician, including obstetrical and gynecological services.

2. Incident To - Services and supplies furnished incident to a nurse midwife's service are covered if they would have been covered when furnished incident to the services of a doctor of medicine or osteopathy, as described in §60.

3. Medical Record Documentation for Part B Services *–This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B certified nurse-midwives covered services, the certified nurse-midwife may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the certified nurse-midwives presence and participation in the service.*

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

D. Noncovered Services

The services of nurse-midwives are not covered if they are otherwise excluded from Medicare coverage even though a nurse-midwife is authorized by State law to perform them. For example, the Medicare program excludes from coverage routine physical checkups and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Coverage of service to the newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother's eligibility.

E. Relationship With Physician

Most States have licensure and other requirements applicable to nurse-midwives. For example, some require that the nurse-midwife have an arrangement with a physician for the referral of the patient in the event a problem develops that requires medical attention. Others may require that the nurse-midwife function under the general supervision of a physician. Although these and similar State requirements must be met in order for the nurse-midwife to provide Medicare covered care, they have no effect on the nurse-midwife's right to personally bill for and receive direct Medicare payment. That is, billing does not have to flow through a physician or facility.

See §60.2 for coverage of services performed by nurse-midwives incident to the service of physicians.

F. Place of Service

There is no restriction on place of service. Therefore, nurse-midwife services are covered if provided in the nurse-midwife's office, in the patient's home, or in a hospital or other facility, such as a clinic or birthing center owned or operated by a nurse-midwife.

G. Assignment Requirement

Assignment is required.

190 - Physician Assistant (PA) Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

Effective for services rendered on or after January 1, 1998, any individual who is participating under the Medicare program as a physician assistant for the first time may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish PA services in the State where the services are performed. PAs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the PA benefit.

See the Medicare Claims Processing Manual, Chapter 12, "Physician and Nonphysician Practitioners," §110, for payment methodology for PA services. Payment is made under assignment only.

A. Qualifications for PAs

To furnish covered PA services, the PA must meet the conditions as follows:

1. Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or

2. Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and

3. Be licensed by the State to practice as a physician assistant.

B. Covered Services

Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General

The services of a PA may be covered under Part B, if all of the following requirements are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets all the PA qualifications,
- They are performed under the general supervision of an MD/DO;
- The PA is legally authorized to perform the services in the state in which they are performed; and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.

2. Incident To

If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in §60.

3. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B physician assistant covered services, the physician assistant may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the physician assistant's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

***4*. Types of PA Services That May Be Covered**

State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. A/B MACs (B) should consider developing lists of covered services. Also, if authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.

Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

See §60.2 for coverage of services performed by PAs incident to the services of physicians.

***5*. Services Otherwise Excluded From Coverage**

The PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a PA's scope of practice under State law.

C. Physician Supervision

The physician supervision requirement under Medicare law is met under the circumstances as follows:

Medicare Part B covers a PA's services only if the PA performs the services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and PA's, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of the PA benefit category under section 1861(s)(2)(K)(i) of the Act. For states with no explicit state law and scope of practice rules regarding physician supervision of PA's services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician/s when furnishing professional services.

D. Employment Relationship

Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories. If the employer of the PA is a professional corporation or other duly qualified legal entity (such as a limited liability company or a limited liability partnership), properly formed, authorized and licensed under State laws and regulations, that permits PA ownership in such corporation nor entity as a stockholder or member, that corporation or entity as the employer may bill for PA services even if a PA is a stockholder or officer of the entity, as long as the entity is entitled to enroll as a "provider of services" or a supplier of services in the Medicare program. Physician Assistants may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. Leasing agencies and staffing companies do not qualify under the Medicare program as "providers of services" or suppliers of services.

200 - Nurse Practitioner (NP) Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he or she is legally authorized to furnish NP services in the State where the services are performed. NPs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the NP benefit.

Payment for NP services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for NPs

In order to furnish covered NP services, an NP must meet the conditions as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2001, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and

- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law;

- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and

- Possess a master's degree in nursing *or a doctor of nursing practice (DNP) doctoral degree*.

B. Covered Services

Coverage is limited to the services an NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law).

1. General

The services of an NP may be covered under Part B if all of the following conditions are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);

- They are performed by a person who meets the definition of an NP (see subsection A);

- The NP is legally authorized to perform the services in the State in which they are performed;

- They are performed in collaboration with an MD/DO (see subsection D); and

- They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)

2. Incident To

If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

3. Medical Record Documentation for Part B Services

This medical record documentation requirment applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B nurse practitioner covered services, the nurse practitioner may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the nurse practitioner's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of NP Services That May Be Covered

State law or regulation governing an NP's scope of practice in the State in which the services are performed applies. Consider developing a list of covered services based on the State scope of practice. Examples of the types of services that NP's may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

See §60.2 for coverage of services performed by NPs incident to the services of physicians.

2. Services Otherwise Excluded From Coverage

The NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under State law.

D. Collaboration

Collaboration is a process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

E. Direct Billing and Payment

Direct billing and payment for NP services may be made to the NP.

F. Assignment

Assignment is mandatory.

210 - Clinical Nurse Specialist (CNS) Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a clinical nurse specialist (CNS) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish CNS services in the State where the services are performed. CNSs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the CNS benefit.

Payment for CNS services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for CNSs

In order to furnish covered CNS services, a CNS must meet the conditions as follows:

1. Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;

2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution *or a doctor of nursing practice (DNP) doctoral degree*; and

3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

B. Covered Services

Coverage is limited to the services a CNS is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General

The services of a CNS may be covered under Part B if all of the following conditions are met:

- They are the types of services that are considered as physician's services if furnished by an MD/DO;
- They are furnished by a person who meets the CNS qualifications (see subsection A);
- The CNS is legally authorized to furnish the services in the State in which they are performed;
- They are furnished in collaboration with an MD/DO as required by State law (see subsection C); and
- They are not otherwise excluded from coverage because of one of the statutory exclusions. (See subsection C.)

2. Types of CNS Services that May be Covered

State law or regulations governing a CNS' scope of practice in the State in which the services are furnished applies. A/B MACs (B) must develop a list of covered services based on the State scope of practice.

Examples of the types of services that a CNS may furnish include services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of his or her State license, a CNS may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

3. Incident To

If covered CNS services are furnished, services and supplies furnished incident to the services of the CNS may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

4. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B Clinical Nurse Specialist (CNS) covered services, the CNS may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the CNS's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of CNS Services

Examples of the types of services that CNS may provide are services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting

x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. State law or regulation governing a CNS' scope of practice for his or her service area applies.

2. Services Otherwise Excluded From Coverage

A CNS' services are not covered if they are otherwise excluded from coverage even though a CNS may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and routine physical checkups and services that are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the function of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a CNS' scope of practice under State law.

See §60.2 for coverage of services performed by a CNS incident to the services of physicians.

D. Collaboration

Collaboration is a process in which a CNS works with one or more physicians (MD/DO) to deliver health care services within the scope of the CNS' professional expertise with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by the CNS documenting his or her scope of practice and indicating the relationships that the CNS has with physicians to deal with issues outside the CNS' scope of practice.

The collaborating physician does not need to be present with the CNS when the services are furnished or to make an independent evaluation of each patient who is seen by the CNS.

E. Direct Billing and Payment

A CNS may bill directly and receive direct payment for their services.

F. Assignment Requirement

Assignment is required for the service to be covered.