CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2024	**Date: August 6, 2010**
	Change Request 7005

Change Request 7005, Transmittal 2024, sent on August 6, 2010, is no longer sensitive. The transmittal number, date issued and all other information remain the same.

SUBJECT: Payment for Certified Nurse-Midwife Services

I. SUMMARY OF CHANGES: This instruction is being updated to reflect the increased Medicare Part B payment amount for certified nurse-midwife (CNM) services from 65 percent of the physician fee schedule to 100 percent of the physician fee schedule amount that would be paid for the same service furnished by a physician.

Payment for CNM services is also increased when furnished to patients in critical access hospitals that are paid under the optional method.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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	4/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule payment for Professional Services
R	12/Table of Contents
R	12/130.1/Payment for Certified Nurse-Midwife Services
R	12/130.2/Global Allowances

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2024	Date: August 6, 2010	Change Request: 7005

Change Request 7005, Transmittal 2024, sent on August 6, 2010, is no longer sensitive. The transmittal number, date issued and all other information remain the same.

SUBJECT: Payment for Certified Nurse-Midwife Services.

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

Section 3114 of the Patient Protections and Affordable Care Act (ACA) of 2010, increased the amount of payment that the Medicare program will make to certified nurse-midwives (CNMs) for their personal professional services and for services furnished incident to their professional services. Since 1992, payment has been made at 80 percent of the lesser of the actual charge or 65 percent of the physician fee schedule amount that would be paid for the same service furnished by a physician. Effective January 1, 2011, payment will be made at 80 percent of the lesser of the actual charge or 100 percent of the physician fee schedule amount that would be paid for the same service furnished by a physician.

A. Background: From January 1, 1992 through December 31, 2010, certified nurse-midwives (CNMs) are paid at 80 percent of the lesser of the actual charge or 65 percent of the physician fee schedule amount that would be paid for the same service furnished by a physician for their services.

B. Policy: Effective on or after January 1, 2011, Medicare will pay certified nurse-midwives (CNMs) for their services at 80 percent of the lesser of the actual charge or 100 percent of the physician fee schedule amount that would be paid for the same service furnished by a physician.

Additionally, policy changes have been made regarding the services that CNMs furnish to patients in critical access hospitals (CAHs) paid under the optional method. These changes reflect the increase in payment for CNM services effective January 1, 2011, and specify the appropriate modifier that must be used when billing for CNM services furnished to patients in this setting.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7005.1	Effective on or after January 1, 2011, contractors shall pay	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	for certified nurse-midwife services furnished to critical access hospital (CAH) patients paid under the optional method on TOB 85X with revenue code 96X, 97X or 98X and modifier SB (Certified Nurse-Midwife) based on the lesser of the actual charge or 100 percent of the Medicare Physician Fee Schedule (MPFS) amount as follows: [(facility- specific MPFS amount) minus (deductible and coinsurance)] times 1.15.										
7005.2	Effective for claims with dates of service from January 1, 1992, through December 31, 2010, contractors shall continue to pay CNMs for their care in connection with a global service at 65 percent of what a physician would have been paid for the total global fee.	X			X			X			
7005.3	Effective on or after January 1, 2011, contractors shall pay CNMs for their care in connection with a global service at 80 percent of the lesser of the actual charge or 100 percent of what a physician would have been paid for the total global fee.	X			X			X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7005.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Regina Walker-Wren at Regina.Walkerwren@cms.hhs.gov for payment policy. Cynthia Glover at Cynthia.Glover@cms.hhs.gov for Part B claims processing. Sue Guerin at Susan.Guerin@cms.hhs.gov or Tracey Mackey at Tracey.Mackey@cms.hhs.gov for Part A claims processing.

Post-Implementation Contact(s): Regional Offices

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*, and or *Carriers:* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev.2024, Issued: 08-06-10, Effective: 01-01-11, Implementation: 01-03-11)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary on an annual basis at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in *e*ffect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS-855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of Form CMS-855R to the intermediary *or A/B MAC,* and the appropriate carrier *or A/B MAC*, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier *or A/B MAC* for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary *or A/B MAC* for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier *or A/B MAC* under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the ANSI X12N 837 I, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI *or A/B MAC* will pay 101 percent of the *reasonable costs for the* outpatient services less applicable Part B deductible and coinsurance amounts, plus:

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

    - The FI *or A/B MAC* uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/*nonphysician practitioner* services rendered in a CAH that elected the *optional* method. The data in the supplemental file are in the same format as the abstract file. *Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15;* and

      For a non-participating physician service, a CAH must place modifier AK on the claim. *Payment is based on the lesser of the actual charge or a reduced fee schedule amount of 95* percent. *Payment is calculated as follows:*

        - *[(facility-specific MPFS amount times the non-participating physician reduction (0.95) minus (deductible and coinsurance] times 1.15.*

        - *If a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) renders a service, the "GF" modifier must be on the applicable line:*

            - GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for *certified registered nurse anesthetist (*CRNA*)* services, the claim is returned to the provider.) *Also, while this national "GF" modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the "GF" modifier for CRN services, no Medicare payment should be made.*

            - *Services billed with the "GF" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated* ***as follows:***

                - *[(facility-specific MPFS amount times the nonphysician practitioner services reduction (0.85) minus (deductible and coinsurance)] times 1.15.*

        - SB - Services rendered in a CAH by a *certified* nurse-midwife.

        - *For dates of service prior to January 1, 2011, certified nurse-midwife services billed with the "SB" modifier are paid based on the lesser of the*

*actual charge or a reduced fee schedule amount of 65 percent. Payment is calculated **as follows:***

- *[(facility-specific MPFS amount times the certified nurse-midwife reduction (0.65) minus (deductible and coinsurance)] times 1.15.*

- *For dates of service on or after January 1, 2011, Medicare covers the services of a certified nurse-midwife. The "SB" modifier is used to bill for the services and payment is based on the lesser of the actual charge or 100 percent of the MPFS. MPFS Payment is calculated **as follows**:*

- *[(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.*

- AH - Services rendered in a CAH by a clinical psychologist.

- *Payment for the services of a clinical psychologist is based on the lesser of the actual charge or 100 percent of the MPFS. Payment is calculated **as follows:***

  - *[(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.*

- AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- *Services billed with the "AE" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:***

  - *[(facility-specific MPFS amount times the registered dietitian reduction (0.85) minus (deductible and coinsurance)] times 1.15.*

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS *code* has a facility rate and a non-facility rate, the facility rate *is paid*.

SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPITAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY*XX*.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture Value	
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.
14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.

16 - Filler 44-60 X(17)

Physician Fee Schedule Payment Policy Indicator File Record Layout

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used to identify endoscopic base codes, payment policy indicators, global surgery indicators or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT code and the associated pricing modifier(s). See Chapter 12 of Pub. 100-04 for more information on payment policy indicators and payment adjustment rules.

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and TC = Technical component. For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical	2 Pic x(2)	10-11

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.		
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.	1 Pic x(1)	12
Global Surgery This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service. 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply.	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
XXX = Global concept does not apply. YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.)		
Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	16-21
Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	22-27
Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	28-33

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to Codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. 6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply		
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). Note: The 4 will be changed to a 9 because the 4 does not apply to Method II CAH claims for professional services processed by the fiscal intermediary. 9 = Concept does not apply.		
Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be paid: 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.	1 Pic (x)1	37
Co-Surgeons (Modifier 62) This field provides an indicator for services for	1 Pic (x)1	38

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.		
Team Surgeons (Modifier 66) This field provides an indicator for services for which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	1 Pic (x)1	39
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Filler	30 Pic x(30)	46-75

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and

Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10 percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA, but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on the report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. The CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev.2024, 08-06-10)

130.1 - Payment for Certified Nurse-Midwife Services

(Rev.2024, Issued: 08-06-10, Effective: 01-01-11, Implementation: 01-03-11)

Payment for certified nurse-midwife *(CNM)* services is *made directly to CNMs for their professional services, and for services furnished incident to their professional services. Also, CNMs are required to accept assigned payment for their services. Accordingly, when CNMs bill for their services under specialty code 42, billing does not have to flow through a physician or facility unless the CNM reassigns their benefits to another billing entity. For reassigned CNM services, the entity bills for CNM services using the specialty code 42 to signify that payment for CNM services is being claimed.*

Prior to December 31, 1991, Medicare Part B payment for CNM services was made at 80 percent of the lesser of the actual charge or, under a fee schedule that did not exceed 65 percent of the prevailing charge. This payment methodology changed and effective January 1, 1992, until December 31, 2010, payment for CNM services is made at 80 percent of the lesser of the actual charge, or 65 percent of the physician fee schedule amount for the same service performed by a physician. However, effective on and after January 1, 2011, payment for CNM services is made at 80 percent of the lesser of the actual charge, or 100 percent of the physician fee schedule amount for the same service performed by a physician.

Payment for covered drugs and biologicals furnished incident to CNMs' services is made according to the Part B drug/biological payment methodology. Covered clinical diagnostic lab services furnished by CNMs are paid according to the clinical diagnostic lab fee schedule. Also, when CNMs furnish outpatient treatment services for mental illnesses, these services could be subject to the outpatient mental health treatment limitation (the limitation). The appropriate percentage payment reduction under the limitation is applied first to the approved amount for the mental health treatment services before the actual payment amount is determined for the CNMs' services. Please refer to §210 *of this manual to determine the appropriate percentage payment reduction under the limitation.*

130.2 - Global Allowances

(Rev.2024, Issued: 08-06-10, Effective: 01-01-11, Implementation: 01-03-11)

When a *certified nurse-midwife* is providing *most of* the care *to a Medicare beneficiary that is part of a global service and a physician also provides a portion of the care for this same global service,* the fee paid to the *CNM for his or her care is* based on the portion of the global fee that would have been paid to the physician for the care provided by the *CNM.*

For example, a *CNM* requests that the physician examine the beneficiary prior to delivery. The *CNM* has furnished the ante partum care and intends to perform the delivery and post partum care. The physician fee schedule amount for the physician's total obstetrical care (global fee) is $1, 000. The physician fee schedule amount for the physician's office visit is $30. The following calculation shows the maximum allowance for the CNM's service:

Physician fee schedule amount for total obstetrical care	$1,000.00
Physician fee schedule amount for visit	- $30.00
Result	$ 970.00
Fee schedule amount for *certified* nurse-midwife (65% x $970, *effective January 1, 1992 thru December 31, 2010.*)	$ 630.50
Fee schedule amount for certified nurse-midwife (100% x 970, effective January 1, 2011.)	$970.00

Therefore, the *certified* nurse-midwife would be paid no more than 80 percent of $630.50, *or 80 percent of $970.00 for services furnished on or after January 1, 2011,* for the care of the beneficiary.

This calculation also applies when a physician provides most of the services and calls in a *certified* nurse-midwife to provide a portion of the care.

Physicians and *certified* nurse-midwives use reduced service modifiers to report that they have not provided all the services covered by the global allowance.