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 the 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. 1, 10-01-03)

B3-2156

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 - 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. Carriers 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.

4 - Services Otherwise Excluded From Coverage

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 PA’s physician supervisor (or a physician designated by the supervising physician or employee, as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.

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 or 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. 1, 10-01-03)

B3-2158

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:
• American Academy of Nurse Practitioners;
• American Nurses Credentialing Center;
• National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
• National Certification Board of Pediatric Nurse Practitioners and Nurses;
• Oncology Nurses Certification Corporation; and
• Critical Care Certification Corporation.

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.

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.

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).

I - 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.

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

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 a NP’s scope of practice under State law.

D - Collaboration

Collaboration is a process in which a 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. 1, 10-01-03)
B3-2160
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; and
3. Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

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).

I - 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. Carriers 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.

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.

**F - 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.

**220 - Coverage of Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services under Medical Insurance**

(Rev. 5, 01-09-04)

B3-2200, A3-3147, HO-241.1

Coverage of outpatient physical therapy, occupational therapy, and outpatient speech-language pathology services under Part B includes such services furnished directly by the provider and also services furnished under arrangements made by a provider, a physician, a non-physician practitioner, a therapist or a supplier qualified to provide the service.

This includes individual practitioners and approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, SNFs, HHAs, CORFs, and other rehabilitation facilities. To qualify as providers of services, clinics, rehabilitation agencies, and public health agencies must meet certain conditions enumerated in the law and enter into an agreement with the Secretary, in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made.

Reimbursement for therapy provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Reimbursement for therapy provided by home health agencies under a plan of treatment is included in the home health PPS rate. Some therapy services are included in hospital outpatient PPS and some are paid under the therapy fee schedule (see the Medicare Claims Processing Instructions for a description of applicable rules).

Therapy may be billed by a home health agency on bill type 34x if there are no home health services billed under a home health plan of care at the same time, and there is a valid plan of treatment (e.g., the patient is not homebound).

**220.1 - Therapy Services Furnished Under Arrangements with Providers and Clinics**

(Rev. 9, 04-23-04)

B3-2203; A3-3147.1; HO-241.1; Pub 100-1, Chapter 5, §10.3

A. General

A provider may have others furnish outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service.