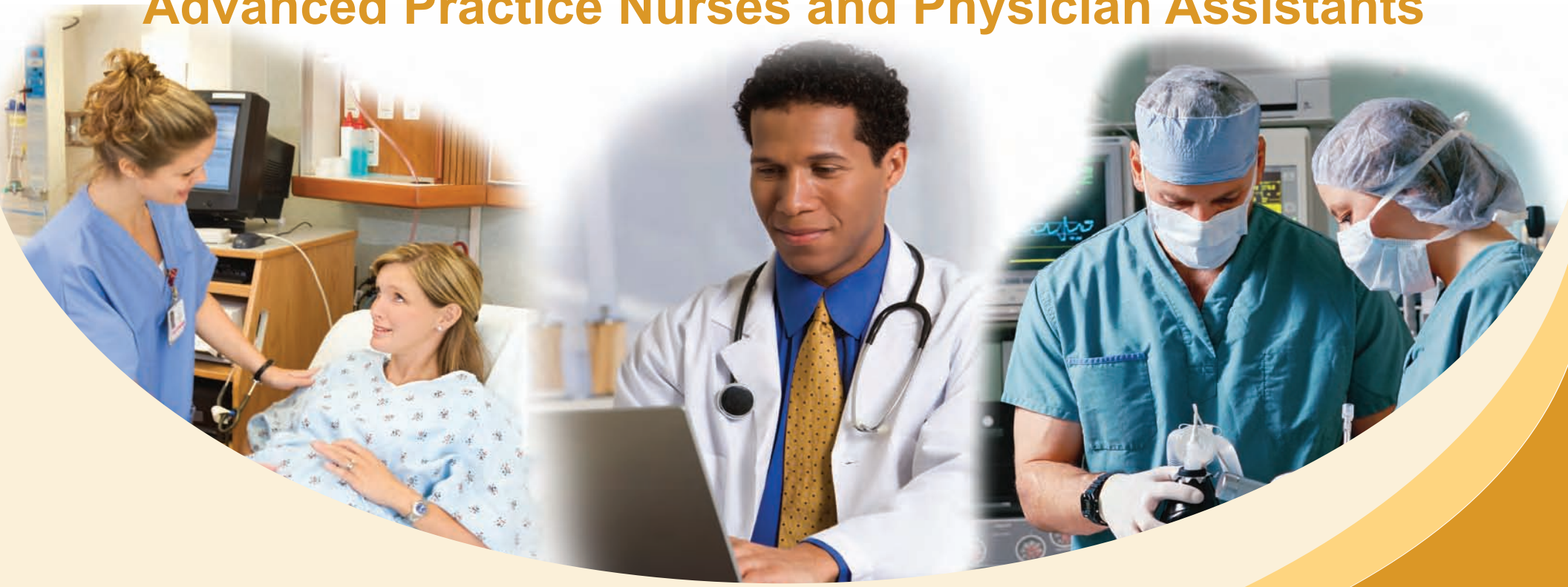
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Information for Advanced Practice Nurses and Physician Assistants



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This publication provides information about required qualifications, coverage criteria, billing, and payment for Medicare services furnished by advanced practice nurses (APN) and physician assistants (PA). APNs include:

- Certified registered nurse anesthetists (CRNA) and anesthesiologist assistants (AA);
- Nurse practitioners (NP);
- Certified nurse-midwives (CNM); and
- Clinical nurse specialists (CNS).

HOW TO USE THIS PUBLICATION

Within each section of this publication, the provider types are color coded to assist the user in finding information of interest. The first page of each section provides information about required qualifications and coverage criteria for the provider type, and the second page of each section provides information about billing and payment for the provider type.

Certified Registered Nurse Anesthetists and Anesthesiologist Assistants

REQUIRED QUALIFICATIONS

- CRNAs must:
  - Be licensed as a registered professional nurse by the State in which he or she practices;
  - Meet any licensure requirements the State imposes with respect to non-physician anesthetists;
  - Have graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs or other accreditation organization designated by the Secretary of the Department of Health and Human Services (HHS); and
  - Meet one of the following:
    - Have passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary of the Department of HHS; or
    - Have graduated from one of the nurse anesthesia educational programs described in the third bullet above; and
    - Have passed the certification examination discussed above within 24 months of graduation.
- AAs must:
  - Work under the direction of an anesthesiologist;
  - Be in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on non-physician anesthetists; and
  - Have graduated from a medical-school based AA education program that:
    - Is accredited by the Committee on Allied Health Education and Accreditation; and
    - Includes approximately two years of specialized science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

COVERAGE CRITERIA

- Services or supplies must be medically reasonable and necessary;[1]
- He or she must be legally authorized and qualified to furnish the services in the State in which they are performed; and
- Unless he or she is located in a State that has opted out of supervision requirements, when general, regional, and monitored anesthesia is administered:
  - By a CRNA, it must be supervised by the operating practitioner performing the procedure or by an anesthesiologist who is immediately available if needed; or
  - By an AA, it must be supervised by an anesthesiologist who is immediately available if needed.[2]

[1]Medically necessary services or supplies:
- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

[2]An anesthesiologist is considered immediately available when he or she:
- Is physically located within the same area as the AA; and
- Is not otherwise occupied in a way that prevents an immediate hands-on intervention.

Certified Registered Nurse Anesthetists and Anesthesiologist Assistants

BILLING

- May bill the Medicare Program either:
  - Directly for services using his or her National Provider Identifier (NPI); or
  - Under an employer's or contractor's NPI;
- Anesthesia time is the continuous period that:
  - Begins when the patient is prepared for anesthesia services in the operating room or equivalent area; and
  - Ends when the patient may be placed safely under postoperative care;
- Blocks of time can be added around an interruption in anesthesia time as long as continuous anesthesia care is furnished within the time periods around the interruption;
- The claim form must include one of the following certifications, as applicable:
  - CRNA or AA services have been medically directed; or
  - CRNA or AA services have not been medically directed;
- Anesthesia billing modifiers include:
  - QX – CRNA Service: With medical direction by a physician;
  - QZ – CRNA Service: Without medical direction by a physician;
  - QS – Monitored anesthesiology care services (can be billed by a CRNA or a physician); and
  - QY – Medical direction of one CRNA by an anesthesiologist; and
- CRNAs are identified on provider file by specialty code 43, and AAs are identified by specialty code 32.

PAYMENT

- Made only on assignment basis;[3]
- Is subject to Medicare Part B deductible and coinsurance;
- Services are paid under the CRNA fee schedule at the lesser of 80 percent of one of the following:
  - The actual charge;
  - The applicable CRNA conversion factor (CF) multiplied by the sum of allowable base and time units; or
  - The applicable locality participating anesthesiologist's CF multiplied by the sum of allowable base and time units; and
- One anesthesia time unit = 15 minutes of anesthesia time.

[3]Assignment means that the provider or supplier:
- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

Nurse Practitioners

REQUIRED QUALIFICATIONS

- Must be a registered professional nurse authorized by the State in which services are furnished to practice as a NP in accordance with State law and meet one of the following:
  - Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003, and:
    - Is certified as a NP by a recognized national certifying body that has established standards for NPs; and
    - Has a Master's degree in nursing or a Doctor of Nursing Practice (DNP) degree;
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2003, and meets the certification requirements described above; or
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2001.

COVERAGE CRITERIA

- Services or supplies must be medically reasonable and necessary;[1]
- The following must be met:
  - Services are performed in collaboration with a physician;[4]
  - Services are the type considered physicians' services if furnished by a medical doctor (MD) or a doctor of osteopathy (DO);
  - Services are not otherwise precluded due to a statutory exclusion; and
  - He or she is legally authorized and qualified to furnish the services in the State where they are performed;
- May be selected as a hospice beneficiary's attending physician, but he or she cannot certify or recertify a terminal illness with a prognosis of six months or less; and
- Incident to services and supplies may be covered.[5]

[1]Medically necessary services or supplies:
- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

[4]Collaboration occurs when NPs or CNSs:
- Work with one or more physicians to deliver health care services within the scope of their professional expertise; and
- Medical direction and appropriate supervision is provided as required by the law of the State in which the services are furnished (it is not required for the collaborating physician to be present when services are furnished or to independently evaluate patients).

[5]Incident to services:
- Must be an integral part of the patient's normal course of treatment during which the physician has personally performed an initial service and remains actively involved in the course of treatment;
- Are commonly furnished without charge (included in the physician's bill);
- Are an expense to the physician;
- Are commonly furnished in the physician's office or clinic; and
- The physician provides direct supervision, which means that he or she is present in the office suite and immediately available if needed.

Nurse Practitioners

BILLING	PAYMENT
❖ May either: • Bill the Medicare Program directly for services using his or her NPI; or • Under an employer's or contractor's NPI; ❖ Incident to services claims must be submitted under the supervising physician's NPI; and ❖ Identified on provider file by specialty code 50.	❖ Made only on assignment basis;[3] ❖ The outpatient mental health treatment limitation applies;[6] ❖ Services are paid at 85 percent of the Medicare Physician Fee Schedule (PFS) amount; and ❖ When services furnished to hospital inpatients and outpatients are billed directly, payment is unbundled and made to the NP.

[3]Assignment means that the provider or supplier:
- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

[6]The outpatient mental health treatment limitation:
- Generally applies to all covered mental health therapeutic services that are performed in an outpatient setting; and
- Effective January 1, 2010, a reduction of 68.75 percent is applied to the 85 percent payment amount under the PFS. However, the percentage payment reduction under the outpatient mental health treatment limitation (the limitation) will continue to change until January 1, 2014, when the limitation will be eliminated.

Certified Nurse-Midwives

REQUIRED QUALIFICATIONS

- Must be licensed to practice in the State as a registered professional nurse and meet one of the following:
  - 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
  - If the State does not specify a program of study and clinical experience that nurse-midwives must complete in order to practice in the State, he or she must meet one of the following:
    - Be currently certified as a nurse-midwife by the American College of Nurse-Midwives;
    - Have completed a formal education program of at least one academic year that, upon completion, qualifies him or her to take the certification examination offered by the American College of Nurse-Midwives; or
    - Have completed a formal education program for preparing registered nurses (RN) to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period and to furnish care to normal newborns. Must also have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, through July 16, 1982.

COVERAGE CRITERIA

- Services or supplies must be medically reasonable and necessary;[1]
- He or she must be legally authorized and qualified to furnish the services in the State in which they are performed;
- Services are covered in all settings including:
  - Offices;
  - Clinics;
  - Birthing centers;
  - Patients' homes; and
  - Hospitals; and
- Incident to services and supplies may be covered.[5]

[1]Medically necessary services or supplies:
- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

[5]Incident to services:
- Must be an integral part of the patient's normal course of treatment during which the physician has personally performed an initial service and remains actively involved in the course of treatment;
- Are commonly furnished without charge (included in the physician's bill);
- Are an expense to the physician;
- Are commonly furnished in the physician's office or clinic; and
- The physician provides direct supervision, which means that he or she is present in the office suite and immediately available if needed.

Certified Nurse-Midwives

BILLING

- May either:
  - Bill the Medicare Program directly for services using his or her NPI; or
  - Under an employer's or contractor's NPI;
- Incident to services claims must be submitted under the supervising physician's NPI;
- Use billing modifier 52 to report that all services covered by the global allowance were not provided by the billing provider (should not be used when billing for split/shared evaluation and management visits); and
- Identified on provider file by specialty code 42.

PAYMENT

- Made only on assignment basis;[3]
- The outpatient mental health treatment limitation applies;[6]
- Services are paid at 80 percent of the lesser of the actual charge or 65 percent of the PFS amount, and effective January 1, 2011, Medicare payment for CNM services will be increased to 80 percent of the lesser of the actual charge or 100 percent of the PFS amount that is paid to a physician; and
- When a CNM provides most of the service and calls in the collaborating physician to provide a portion of the care or when the physician provides most of the service and calls in a CNM, payment is based on the portion of the global fee that would have been paid to the other provider.

[3]Assignment means that the provider or supplier:
- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

[6]The outpatient mental health treatment limitation:
- Generally applies to all covered mental health therapeutic services that are performed in an outpatient setting; and
- Effective January 1, 2010, a reduction of 68.75 percent is applied to the 85 percent payment amount under the PFS. However, the percentage payment reduction under the outpatient mental health treatment limitation (the limitation) will continue to change until January 1, 2014, when the limitation will be eliminated.

Clinical Nurse Specialists

REQUIRED QUALIFICATIONS

- Must meet the following:
  - Is a RN currently licensed to practice in the State where he or she practices and is authorized to furnish the services of a CNS in accordance with State law;
  - Has a DNP or Master's degree in a defined clinical area of nursing from an accredited educational institution; and
  - Is certified as a CNS by a recognized national certifying body that has established standards for CNSs.

COVERAGE CRITERIA

- Services or supplies must be medically reasonable and necessary;[1]
- All of the following must be met:
  - Services are performed in collaboration with a physician;[4]
  - Services are the type considered physicians' services if furnished by a MD or a DO;
  - Services are not otherwise precluded due to a statutory exclusion; and
  - He or she is legally authorized and qualified to furnish the services in the State where they are performed; and
- Incident to services and supplies may be covered.[5]

[1]Medically necessary services or supplies:
- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

[4]Collaboration occurs when NPs or CNSs:
- Work with one or more physicians to deliver health care services within the scope of their professional expertise; and
- Medical direction and appropriate supervision is provided as required by the law of the State in which the services are furnished (it is not required for the collaborating physician to be present when services are furnished or to independently evaluate patients).

[5]Incident to services:
- Must be an integral part of the patient's normal course of treatment during which the physician has personally performed an initial service and remains actively involved in the course of treatment;
- Are commonly furnished without charge (included in the physician's bill);
- Are an expense to the physician;
- Are commonly furnished in the physician's office or clinic; and
- The physician provides direct supervision, which means that he or she is present in the office suite and immediately available if needed.

Clinical Nurse Specialists

BILLING	PAYMENT
❖ May bill the Medicare Program: • Directly for services using his or her NPI; or • Under an employer's or contractor's NPI; ❖ Incident to services claims must be submitted under the supervising physician's NPI; and ❖ Identified on provider file by specialty code 89.	❖ Made only on assignment basis;[3] ❖ The outpatient mental health treatment limitation applies;[6] ❖ Services are paid at 85 percent of the PFS amount; and ❖ When services furnished to hospital inpatients and outpatients are billed directly, payment is unbundled and made to the CNS.

[3]Assignment means that the provider or supplier:
- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

[6]The outpatient mental health treatment limitation:
- Generally applies to all covered mental health therapeutic services that are performed in an outpatient setting; and
- Effective January 1, 2010, a reduction of 68.75 percent is applied to the 85 percent payment amount under the PFS. However, the percentage payment reduction under the outpatient mental health treatment limitation (the limitation) will continue to change until January 1, 2014, when the limitation will be eliminated.

Physician Assistants

REQUIRED QUALIFICATIONS

- Must be licensed by the State to practice as a PA and either:
  - Have graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs, and the Committee on Allied Health Education and Accreditation); or
  - Have passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

COVERAGE CRITERIA

- Services or supplies must be medically reasonable and necessary;[1]
- The following must be met:
  - Services are the type considered physician's services if furnished by a MD or a DO;
  - Services are performed by an individual who meets all PA qualifications;
  - Services are performed under the general supervision of a MD or a DO;
  - Services are not otherwise precluded from coverage because of statutory exclusion; and
  - He or she is legally authorized to furnish the services in the State in which they are performed;
- The physician supervisor or designee need not be physically present when a service is being furnished unless State law or regulations require otherwise; and
- Incident to services and supplies may be covered.[5]

[1]Medically necessary services or supplies:
- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

[5]Incident to services:
- Must be an integral part of the patient's normal course of treatment during which the physician has personally performed an initial service and remains actively involved in the course of treatment;
- Are commonly furnished without charge (included in the physician's bill);
- Are an expense to the physician;
- Are commonly furnished in the physician's office or clinic; and
- The physician provides direct supervision, which means that he or she is present in the office suite and immediately available if needed.

Physician Assistants

BILLING

- When billing the Medicare Program for PA services:
  - The PA's W-2 employer or 1099 independent contractor must bill under the PA's NPI; or
  - May bill under a physician's NPI only if the physician in the group practice/employer has performed a visit that assesses the patient and establishes a plan of care;
- If employed by a hospital or Skilled Nursing Facility (SNF), the hospital or SNF must bill for the professional services;
- Incident to services claims must be submitted under the supervising physician's NPI;
- For assistant at surgery claims, use the AS modifier and one of the following:
  - Modifier 80 – Assistant surgeon services;
  - Modifier 81 – Minimum assistant surgeon services; or
  - Modifier 82 – Assistant surgeon services (when assistant resident surgeon is not available); and
- Identified on provider file by specialty code 97.

PAYMENT

- Made only on assignment basis;[3]
- The outpatient mental health treatment limitation applies;[6]
- May be made only to his or her:
  - Qualified employer who is eligible to enroll in the Medicare Program under existing provider/supplier categories; or
  - Contractor; and
- Services are paid at 80 percent of the lesser of the actual charge or 85 percent of the PFS amount except:
  - Assistant at surgery services, which are paid at 85 percent of 16 percent of the PFS amount.

[3]Assignment means that the provider or supplier:
- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

[6]The outpatient mental health treatment limitation:
- Generally applies to all covered mental health therapeutic services that are performed in an outpatient setting; and
- Effective January 1, 2010, a reduction of 68.75 percent is applied to the 85 percent payment amount under the PFS. However, the percentage payment reduction under the outpatient mental health treatment limitation (the limitation) will continue to change until January 1, 2014, when the limitation will be eliminated.

Resources

Additional information about services furnished by APNs and PAs is available as follows:

- At ***http://www.cms.gov/MLNProducts/70_APNPA.asp*** on the Centers for Medicare & Medicaid Services (CMS) website; and
- In the ***Medicare Benefit Policy Manual*** (Pub. 100-02) and the ***Medicare Claims Processing Manual*** (Pub. 100-04) located at ***http://www.cms.gov/Manuals/IOM/list.asp*** on the CMS website.

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