

PART B



**Physician Assistant
Nurse Practitioner
Clinical Nurse Specialist
Certified Nurse-Midwife
Billing
Guide
February 2010**

NHIC, Corp.

Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS),
and Certified Nurse-Midwife (CNM) Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse-Midwife billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-2, Chapter 15 and Publication 100-4, Chapter 12 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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PHYSICIAN ASSISTANT (PA) SERVICES

General Information

The professional services of a Physician Assistant (PA) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable State licensure laws, but only if no facility or other provider charges or are paid with respect to the furnishing of such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for PAs

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

- 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
- Passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the State to practice as a physician assistant.

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). 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.

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. 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 examinations (including the initial preventive physical examination), minor surgery, setting casts or simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

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 exams, 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.

Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer 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.

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. PAs 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. A leasing agency and staffing company do not qualify under the Medicare program as a "provider of services" or "supplier of services". Payment for PA services is made only to the PA's employer, whether the PA is employed as a W-2 employee or as a 1099 employee. While a PA has an option in terms of selecting employment arrangements, only the "employer" can bill a carrier for the PA's services.

NURSE PRACTITIONER (NP) SERVICES

General Information

The professional services of a Nurse Practitioner (NP) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable state licensure laws. Nurse Practitioners are also authorized to bill the Medicare program directly for their services when furnished in any area or setting. However, no separate payment will be made when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for NPs

NPs who applied for a Medicare billing number for the first time from January 1, 2001, through December 31, 2002 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 who apply 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.

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;
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

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NOTE: As stated above, Medicare regulations for NPs require that the NP must possess a master's degree in nursing from an accredited educational institution.

It has come to the attention of CMS that some educational institutions are offering educational programs to prospective NPs wherein, students who complete these nursing education programs are allowed to move from a baccalaureate degree in nursing directly to the doctoral degree in nursing where they earn the terminal clinical degree titled the Doctor of Nursing Practice (DNP). Therefore, some advanced practice nurses who earn the DNP do not receive a master's degree in nursing even though they will have met all of the educational requirements for a master's degree, in addition to the preparation that merits them the DNP degree.

Accordingly, CMS requests that Medicare contractors permit NPs with a master's degree in nursing **or a** DNP degree from an accredited institution to enroll into the Medicare program as long as they also meet all of the other respective qualification requirements to participate under the Medicare Part B benefit for NPs.

Covered Services

Coverage is limited to the services a NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a 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 a NP;
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with a MD/DO, and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.

Types of NP Services That May Be Covered

State law or regulation governing a NP's scope of practice in the State in which the services are performed applies. Examples of the types of services that NPs may furnish include services that traditionally have been reserved to physicians, such as examinations (including the initial preventive physical examination), 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.

Medicare pays for nurse practitioner services to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as his/her attending physician with the exception of certifying the terminal illness with a prognosis of 6 months or less. A physician will be required to certify the terminal illness and 6 month prognosis.

Services Otherwise Excluded From Coverage

NP services may not be covered if they are otherwise excluded from coverage even though a NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical exams, 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.

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.

CLINICAL NURSE SPECIALIST (CNS) SERVICES

General Information

The professional services of a Clinical Nurse Specialist (CNS) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. Payments are allowed for assistant at surgery services and services furnished in all areas and settings permitted under applicable state licensure laws. Clinical Nurse Specialists are also authorized to bill the Medicare program directly for their services when furnished in any area or setting. However, no separate payment will be made when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for CNSs

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

- 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;
- Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

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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;
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

NOTE: As stated above, Medicare regulations for CNSs require that the CNS must possess a master's degree in nursing from an accredited educational institution.

It has come to the attention of CMS that some educational institutions are offering educational programs to prospective CNSs wherein, students who complete these nursing education programs are allowed to move from a baccalaureate degree in nursing directly to the doctoral degree in nursing where they earn the terminal clinical degree titled the Doctor of Nursing Practice (DNP). Therefore, some advanced practice nurses who earn the DNP do not receive a master's degree in nursing even though they will have met all of the educational requirements for a master's degree, in addition to the preparation that merits them the DNP degree.

Accordingly, CMS requests that Medicare contractors permit CNSs with a master's degree in nursing **or a** DNP degree from an accredited institution to enroll into the Medicare program as long as they also meet all of the other respective qualification requirements to participate under the Medicare Part B benefit for NPs.

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). 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;
- 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; and
- They are not otherwise excluded from coverage because of one of the statutory exclusions.

Types of CNS Services that May be Covered

State law or regulations governing a CNS's scope of practice in the State in which the services are furnished applies. Examples of the types of services that CNSs may furnish include services that traditionally have been reserved for physicians, such as examinations (including the initial preventive physical examination), 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, CNSs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

Services Otherwise Excluded From Coverage

A CNS's 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 exams and services that are not reasonable and necessary for 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 CNS's scope of practice under State law.

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 CNSs 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's 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.

CERTIFIED NURSE-MIDWIFE (CNM) SERVICES

General Information

The professional services of a Certified Nurse-Midwife (CNM) may be covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish services in the State where the services are performed. There is no restriction on the place of service. The services are covered if provided in the CNM'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 CNM.

Qualifications for CNM

A CNM 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.

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

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

Meet one of the following requirements:

- 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 to practice in that State, the nurse-midwife must:
 - Be currently certified as a nurse-midwife by the American College of Nurse-Midwives;
 - 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
 - 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.

Covered Services

Coverage is available for services furnished by a CNM 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.

Services Otherwise Excluded From Coverage

The services of CNMs are not covered if they are otherwise excluded from Medicare coverage even though a CNM 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. Therefore, these services are precluded from coverage even though they may be within the CNM's scope of practice.

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.

Relationship with Physician

Most States have licensure and other requirements applicable to CNMs. For example, some require that the CNM 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 CNM function under the general supervision of a physician. Although these and similar State requirements must be met in order for the CNM to provide Medicare covered care, they have no effect on the CNM's right to personally bill for and receive direct Medicare payment. That is, billing does not have to flow through a physician or facility.

INCIDENT-TO SERVICES

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services. A practitioner includes a physician assistant, nurse practitioner, clinical nurse specialist, and certified nurse-midwife. For purposes of this section physician also means practitioner/PA, NP, CNS, CNM. Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services must be performed under the physician's direct supervision. Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.

To be covered incident to the services of a physician, services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics;
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

It is within Medicare benefit categories that a PA, NP, CNS, or CNM may enroll in the Medicare program and provide services without direct supervision and have the service covered. However, these specialties may opt to provide services incident to an MD or DO. It is not within Medicare benefit categories for auxiliary personnel such as registered nurses or licensed practical nurses to enroll in the Medicare program or provide services without direct supervision. Such auxiliary personnel may only provide services under the incident to guidelines.

Auxiliary personnel is defined as any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

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This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment. Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel is performing services.

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution do not constitute direct supervision. For hospital patients (inpatient, outpatient, ER), and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services. Such services can be covered only under the hospital or SNF benefit.

To summarize, incident to services are allowable in the office and home setting only. A PA, NP, CNS, and CNM can provide services incident to an MD or DO if they choose. For services provided by auxiliary personnel to be covered incident to, the physician or non-physician practitioner (NPP) must perform the initial service, diagnose the patient's medical condition, develop a treatment plan, and remain actively involved in the management of the care of the patient.

NHIC suggests the physician or practitioner review the progress and co-sign the charts. When services are billed incident to a MD, it is as if the MD personally performed the services. When a MD personally performs a service, the MD signs the chart. The MD is personally responsible for all the incident to services rendered to the patient, so co-signing the chart confirms his understanding of his responsibility & liability for the billed services. This also confirms that the MD is actively involved in the patient care and is aware of the patient's status at all times.

Incident-To for Homebound Patients

In some medically underserved areas there are only a few physicians available to provide services over broad geographic areas or to a large patient population. The lack of medical personnel (and, in many instances, a home health agency servicing the area) significantly reduces the availability of certain medical services to homebound patients. Some physicians and physician-directed clinics, therefore, call upon nurses and other paramedical personnel to provide these services under general (rather than direct) supervision. In some areas, such practice has tended to become the accepted method of delivery of these services.

An individual does not have to be bedridden to be considered as confined to home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving his or her home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration.

The direct supervision criterion is **not** applicable when certain services are performed by personnel meeting any pertinent State requirements and where the criteria listed below are also met:

- The patient is homebound; i.e., confined to his or her home.
- The service is an integral part of the physician's service to the patient (the patient must be one the physician is treating), and is performed under **general** physician supervision by employees of the physician or clinic.
- The services are included in the physician's/clinic's bill, and the physician or clinic has incurred an expense for them.
- The services of the auxiliary personnel are required for the patient's care; that is, they are reasonable and necessary.
- When the service can be furnished by a Home Health Agency (HHA) in the local area, it **cannot** be covered.

Note: General supervision means that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control. The physician orders the service(s) to be performed, and contact is maintained between the auxiliary personnel and the physician, e.g., the employee contacts the physician directly if additional instructions are needed, and the physician must retain professional responsibility for the service.

Covered Services

When the above requirements are met, the direct supervision requirement is not applicable to the following services:

- Injections;
- Venipuncture;
- EKGs;
- Therapeutic exercises;

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- Insertion and sterile irrigation of a catheter;
- Changing of catheters and collection of catheterized specimen for urinalysis and culture;
- Dressing changes, e.g., the most common chronic conditions that may need dressing changes are decubitus care and gangrene;
- Replacement and/or insertion of nasogastric tubes;
- Removal of fecal impaction, including enemas;
- Sputum collection for gram stain and culture, and possible acid-fast and/or fungal stain and culture;
- Paraffin bath therapy for hands and/or feet in rheumatoid arthritis or osteoarthritis;
- Teaching and training the patient for:
 - a. The care of colostomy and ileostomy;
 - b. The care of permanent tracheostomy;
 - c. Testing urine and care of the feet (diabetic patients only); and
 - d. Blood pressure monitoring.

SPLIT/SHARED E/M SERVICE

Medically Necessary Encounter

A split/shared E/M visit is defined as a medically necessary encounter with a patient where the physician and a qualified non-physician practitioner (NPP) each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to consultation services, critical care services, or procedures. A split/shared E/M visit cannot be reported in the SNF/NF settings.

Office Setting

In the office/clinic setting, when only the physician performs the E/M service the service must be reported using the physician's NPI. When an E/M service is a split/shared encounter between a physician and a NPP and the service is for an established patient and previously diagnosed medical condition, the service can be billed under the physician's NPI. All incident to requirements must be met.

When the service is split/shared between the physician and the NPP and the service is for a new patient or new medical condition, the service must be billed under the NPP's NPI. Incident to requirements do not apply since this is a new patient or new condition.

Hospital Setting

In the hospital setting, when the service is split/shared between a physician and a NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's NPI. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's NPI.

Examples:

In an office setting, the NPP performs a portion of the E/M encounter and the physician completes the service. If the incident to requirements are met, the physician reports the service. If the incident to requirements are not applicable, the NPP reports the service.

In a hospital setting, if the NPP sees an inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, either the physician or NPP may report the service.

SERVICES RENDERED IN A NURSING FACILITY

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs.

The initial visit in a **SNF** must be performed by the physician. The initial visit is defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission. Further, per the Long Term Care regulations, the physician may not delegate a task that the physician must personally perform. Therefore, the physician may not delegate the initial visit in a SNF.

The initial visit in the **NF** may be performed by a qualified non-physician practitioner, who is **not** employed by the facility, when the State law permits this. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration (for NP, CNS) and physician supervision (for PA) shall be met.

Other medically necessary E/M visits for the diagnosis or treatment of an illness or injury may be performed and reported **prior to** and **after** the initial visit, if the medical needs of the patient require an E/M visit. A qualified non-physician practitioner may perform these medically necessary E/M visits if all the requirements for collaboration (for NP, CNS), general physician supervision (for PA), licensure and billing are met.

Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Certified Nurse-Midwife (CNM) Billing Guide

Payment is made under the physician fee schedule for federally mandated visits. Following the initial visit, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Subsequent nursing facility care codes shall be used to report federally mandated E/M visits as well as medically necessary E/M visits. The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The non-physician practitioner shall bill only one E/M visit. Non-physician practitioners are not able to bill for more frequent visits than those that are medically necessary, or federally mandated, even if a state requires more frequent visits.

Non-physician practitioners may not sign the initial orders for a SNF resident. However, they may write initial orders for a SNF resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician. A physician does not have to sign orders if no orders are necessary or written. For example, for Federally required visits, it is not always necessary to write orders, so no physician signature would be required.

NPs and CNSs who are **not** employed by the SNF may certify and recertify that the services the beneficiary requires may only be performed in the SNF. By statute, PAs may not sign SNF certifications/recertifications. In order to sign certifications/recertifications, the NP or CNS may not have a direct or indirect employment relationship with the SNF, for example, they may not be employed by an organization related to the SNF.

SERVICES IN A RURAL HEALTH CENTER (RHC) OR A FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Separate payment for the professional services provided in a RHC or FQHC setting is not permitted. These services are bundled with other facility services when furnished to patients under the RHC or FQHC benefits. The payment made to these facilities under the all-inclusive rate specifically accounts for the services for the non-physician practitioner because the facility payment rate reflects the costs for these services.

REIMBURSEMENT RATE

PAAs, NPs, CNSs

The payment for PAs, NPs and CNSs is 80 percent of the lesser of either the actual charge or 85 percent of the physician's fee schedule amount. For assistant at surgery services, payment equals 80 percent of the lesser of either the actual charge or 85 percent of the physicians fee schedule amount paid to a physician serving as an assistant at surgery. A physician serving as an assistant at surgery receives 16 percent of the physician fee schedule amount. The PA, NP, and CNS allowance is 85 percent of the 16 percent.

CNM

The payment for CNM services is 80 percent of the lesser of either the actual charge or 65 percent of the physician's fee schedule amount. When a CNM is providing care to a Medicare beneficiary and the collaborating physician provides some of the services, the fee paid to the CNM is based on the portion of the global fee that would have been paid to the physician for the service provided by the CNM. For example, a CNM requests that the physician examine the beneficiary, per their collaborative agreement, prior to the delivery. The CNM has provided 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 \$100. 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 | \$ -100.00 |
| Result | \$ 900.00 |
| Fee schedule amount for nurse-midwife (65% x \$900) | \$ 585.00 |

Therefore, the CNM would be paid no more than 80 percent of \$585.00 for the care of the beneficiary. This calculation also applies when a physician provides most of the services and calls in a CNM to provide a portion of the care. Physicians and CNMs use reduced service modifiers (modifier 52) to report that they have not provided all the services covered by the global allowance.

ASSISTANT AT SURGERY

The 'AS' modifier is defined as physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. Assistant at surgery claims for PAs, NPs and CNSs **must** be submitted with the AS modifier.

The '80' modifier is defined as surgical assistant services. The '81' modifier is defined as minimum surgical assistant services. Assistant at surgery claims for CNMs **must** be submitted with one of these modifiers.

OUTPATIENT MENTAL HEALTH LIMITATION

The outpatient mental health limitation applies to all covered mental health therapeutic services furnished by PAs, NPs, CNSs, and CNMs when performed in an outpatient setting. The limitation does not apply to services performed in an inpatient setting (inpatient hospital, inpatient psychiatric facility or comprehensive outpatient rehabilitation facility).

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase in a 5-year reduction to the payment that Medicare patients are required to make for outpatient mental health services that are subject to the outpatient mental health treatment limitation. Payment for outpatient mental health services will gradually reduce from 2010-2014. Effective January 1, 2014, the limitation will no longer exist and Medicare will pay outpatient mental health services at the same level as other Part B services. The limitation prior to 2010 is 62.5 percent applied after the 85 percent.

Limitation Phase-Out:

January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%

January 1, 2012 – December 31, 2012, the limitation percentage is 75%

January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%

January 1, 2014 – onward, the limitation percentage is 100%

BILLING REQUIREMENTS

Mandatory Assignment

Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse-Midwives must accept assignment on all claims. Mandatory assignment means the PA, NP, CNS, and CNM must accept the Medicare allowed amount as payment in full and may not bill or collect from the beneficiary any amount other than unmet deductible and /or coinsurance amounts.

Incident to Services

When a PA, NP, CNS or CNM renders services incident to a physician, submit the claim under the supervising physician's NPI. Services are billed as if the physician personally performed them. When auxiliary personnel render services incident to a PA, NP, CNS, or CNM submit the claim under the supervising PA, NP, CNS, or CNM. Services are billed as if the PA, NP, CNS, or CNM personally performed the service. All incident to requirements must be met.

National Provider Identifier (NPI)

Physician Assistant

Payment of PA services is made only to the PA's employer. If the employer is a group practice, the group must include their group NPI in Item 33a, including name and address and list the individual PA's NPI in Item 24J on the CMS 1500 claim form or electronic equivalent.

If the employer is a sole proprietor, he/she must include his/her individual NPI in Item 33a, including the name and address and list the individual PA's provider number in 24J on the CMS 1500 claim form or electronic equivalent.

Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse-Midwife

NPs, CNSs, and CNMs can bill the Medicare program directly for their services or reassign payments to an employer. When NPs, CNSs, and CNMs are rendering services and wish to receive payment directly, the NPI of the NP, CNS, or CNM must be entered in Item 33a, including the name and address, on the CMS 1500 claim form or electronic equivalent.

If the employer is a group practice, the group must include their group NPI in Item 33a, including name and address and list the individual NP, CNS, or CNM number in Item 24J on the CMS 1500 claim form or electronic equivalent.

If the employer is a sole proprietor, he/she must include his/her individual NPI in Item 33a, including the name and address and list the individual NP, CNS, or CNM NPI in 24J on the CMS 1500 claim form or electronic equivalent.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://cms.hhs.gov/BNI/>

ABN Modifiers

Modifier **GA** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier **GY** should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier **GZ** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.hhs.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS),
and Certified Nurse-Midwife (CNM) Billing Guide

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

New England:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m.- Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m.- Friday

877-757-7781

MAILING ADDRESS DIRECTORY

| | |
|---|--|
| Initial Claim Submission | |
| Maine | P.O. Box 2323 Hingham, MA 02044 |
| Massachusetts | P.O. Box 1212 Hingham, MA 02044 |
| New Hampshire | P.O. Box 1717 Hingham, MA 02044 |
| Rhode Island | P.O. Box 9203 Hingham, MA 02044 |
| Vermont | P. O. Box 7777 Hingham, MA 02044 |
| EDI (Electronic Data Interchange) | P.O. Box 9104 Hingham, MA 02044 |
| Written Correspondence | P.O. Box 1000 Hingham, MA 02044 |
| Medicare Reopenings and Redeterminations **See note below | P.O. Box 3535 Hingham, MA 02044 |
| Medicare B Refunds | P.O. Box 5912 New York, NY 10087-5912 |
| Medicare Secondary Payer (Correspondence Only) | P.O. Box 9100 Hingham, MA 02044 |
| Provider Enrollment | P.O. Box 3434 Hingham, MA 02044 |
| Medicare Safeguard Services | P.O. Box 4444 Hingham, MA 02044 |

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased use of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

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|---|--|
| Advance Beneficiary Notice (ABN) | http://cms.hhs.gov/BNI/ |
| American Medical Association | http://www.ama-assn.org/ |
| CMS | http://www.cms.hhs.gov http://www.medicare.gov |
| CMS Correct Coding Initiative | http://www.cms.hhs.gov/NationalCorrectCodInitEd/ |
| CMS Physician's Information Resource for Medicare | http://www.cms.hhs.gov/center/physician.asp? |
| Electronic Prescribing | http://www.cms.hhs.gov/erxincentive/ |

Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS),
and Certified Nurse-Midwife (CNM) Billing Guide

Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.hhs.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.hhs.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.hhs.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History

| Version | Date | Reviewed By | Approved By | Summary of Changes |
|---------|------------|-------------------------------|---------------|---|
| 1 | 02/2004 | M. Barr | M. Kelly | Combined PA, NP, CNS guides into one. |
| 2 | 4/2004 | S. Kimball | B. Bedard | Revised contents |
| 3 | 9/1/2004 | D. Perrine | S. Kimball | Revised contents |
| 4.0 | 5/9/2006 | A. Randall/ S. Kimball | M. Kelly | Added summary of incident to services, revised homebound section, added split/shared services, updated Nursing Facility section |
| 5.0 | 09/21/06 | S Kimball and . A. Randall | M. Kelly | Updated NHIC name |
| 6.0 | 04-30-07 | S. Kimball/S. Young | Michele Kelly | Annual Review , clarified split/shared with examples, added CNM guidelines and updated other sections to include CNM |
| 7.0 | 10-15-07 | S. Kimball, S. Young | M. Kelly | Annual Review - Updated NP & CNS certifying bodies; cleaned up formatting. |
| 8.0 | 10-01-08 | S. Kimball | M. Clark | Annual Review Added note on DNP for NPs and CNSs. Removed CA references. |
| 9.0 | 06-23-09 | Susan Kimball | Mylene Clark | Annual Review Removed payment for NPPs in SNF, updated to NPI, J14 template |
| 10.0 | 02/03/2010 | Susan Kimball | Mylene Clark | Annual Review Updated mental health limitation, verified content |

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.hhs.gov>

<http://www.medicare.gov>