CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2656	**Date: February 7, 2013**
	Change Request 8010

Transmittal 2610, dated December 14, 2012, is being rescinded and replaced by Transmittal 2656, dated February 07, 2013, to clarify that modifiers AH and AJ are not being eliminated, but will no longer be required to be submitted. All other information remains the same.

SUBJECT: Update To Publication 100-04, Claims Processing Instructions For Chapter 12, Non-Physician Practitioners (NPPs)

I. SUMMARY OF CHANGES: This CR will delete and or correct obsolete and erroneous billing information to Publication 100-04, Chapter 12 of the Internet Only Manual (IOM) as it relates to nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), clinical psychologists (CPs), and clinical social workers (CSWs).

EFFECTIVE DATE: February 19, 2013
IMPLEMENTATION DATE: February 19, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/20.4.3/Assistant-at-Surgery Services
R	12/110/Physician Assistant (PA) Services Payment Methodology
N	12/110.1/Global Surgical Payments
R	12/110.2/Limitations for Assistant-at-Surgery Services Furnished by Physician Assistants
R	12/110.3/Outpatient Mental Health Treatment Limitation
R	12/110.4/PA Billing to the Contractor
R	12/120/Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services Payment Methodology
N	12/120.1/Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists
R	12/120.2/Outpatient Mental Health treatment Limitation
N	12/120.3/NP and CNS Billing to the Contractor
R	12/150/Clinical Social Worker (CSW) Services
R	12/170.1/Payment

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

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2656	Date: February 7, 2013	Change Request: 8010

Transmittal 2610, dated December 14, 2012, is being rescinded and replaced by Transmittal 2656, dated February 7, 2013, to clarify that modifiers AH and AJ are not being eliminated, but will no longer be required to be submitted. All other information remains the same.

SUBJECT: Update To Publication 100-04, Claims Processing Instructions For Chapter 12, Non-Physician Practitioners (NPPs)

EFFECTIVE DATE: February 19, 2013
IMPLEMENTATION DATE: February 19, 2013

I. GENERAL INFORMATION

A. Background: This CR consists of a set of instructions that includes updated information and changes to Publication 100-04, Chapter 12, and the usage of modifiers for NPPs and, payment for the professional services of NPPs, as well as assistant-at-surgery services furnished by NPPs. These instructions pertain to physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), clinical psychologists (CPs) and clinical social workers (CSWs).

B. Policy: NPP assistant-at-surgery services should be billed with the "AS" modifier only. The health professional shortage area (HPSA) payment modifiers, "QB" and "QU" have been eliminated because they are no longer valid. The "AH" modifier for CPs and, the "AJ" modifier for CSWs will no longer be required to be submitted as they are no longer necessary for identification purposes. The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under the Medicare Physician Fee Schedule (MPFS). Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8010.1	Contractors shall review sections 20.4.3, 110, 120, 150 and 170 under this CR to reconcile and be aware of all the changes to these sections in the Medicare Claims Processing Manual.		X			X						
8010.2	Contractors shall update internal processes as necessary to accommodate these newly revised manual instructions for physician assistants (PAs), nurse		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), clinical social workers (CSWs) and clinical psychologists (CPs).											
8010.3	Contractors shall not require the submission of modifier "AJ" for clinical social workers (CSWs) or modifier "AH" for clinical psychologists (CPs).		X			X						
8010.4	Contractors shall pay the employer of a PA or a provider/supplier for which a PA furnishes services as an independent contractor for PA services at 80 percent of the lesser of the actual charge or 85 percent of the amount that a physician is paid under the Medicare Physician Fee Schedule.		X			X						
8010.5	Contractors shall pay the employer or a provider/supplier when a PA furnishes services as an independent contractor for PA assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of the amount that a physician is paid under the Medicare Physician Fee Schedule for assistant-at-surgery services. Physicians are paid 16 percent of the MPFS amount for the surgical services for which they assist.		X			X						
8010.6	Contractors shall pay NPs and CNSs for assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of 16 percent of the amount that a physician is paid under the Medicare Physician Fee Schedule for assistant-at-surgery services.		X			X						
8010.7	Contractors shall require that claims submitted for assistant-at-surgery services furnished by PAs, NPs and CNSs must be reported with the "AS" modifier only appended to the applicable HCPCS codes.		X			X						
8010.8	Contractors shall require that claims submitted for assistant-at-surgery services furnished by physicians must be reported with only the "-80, -81 or -82" modifier appended to the applicable HCPCS codes. Additionally, assistant-at-surgery services furnished by physicians must be paid at 80 percent of the lesser of the actual charge or 16 percent of the Medicare Physician Fee Schedule payment for surgical services.		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8010.9	Contractors shall review sections 20.4.3, 110, 120, 150 and 170 under this CR to reconcile and be aware of all the changes to these sections in the Medicare Claims Processing Manual.		X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8010.10	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X			X		

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi, 410-786-7544 or L.Trazzi@cms.hhs.gov, Regina Walker-Wren, 410-786-9160 or regina.walkerwren@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

20.4.3 – Assistant-at-Surgery Services

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the *surgical payment*.
Contractors may not pay assistants-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews.
Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, pay claims for procedures with these modifiers only if the services of an assistant-*at-surgery* are authorized.
Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant-at-surgery service for these procedures may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act.) Penalties vary based on the frequency and seriousness of the violation.

110 - Physician Assistant (PA) Services Payment Methodology

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

See *chapter 15, section 190 of* the Medicare Benefit Policy Manual, *pub. 100-02,* for coverage policy for *physician* assistant (PA) services.

Physician *a*ssistant services are paid at *80 percent of* the lesser of the actual charge or 85 percent of *what a physician is paid under* the *Medicare P*hysician *F*ee *S*chedule*. There is a separate payment policy for paying for PA assistant-at-surgery services. See section 110.2 of this chapter.*

110.1 - Global Surgical Payments

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

When a PA furnishes services to a patient during a global surgical period, contractors shall determine the level of PA involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims. PA services furnished during a global surgical period shall be paid at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the Medicare Claims Processing Manual, pub. 100-04.

110.*2* - Limitations for Assistant-at-Surgery Services *Furnished by Physician Assistants*

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that a PA furnishes as an assistant-at-surgery. Specifically, when a PA actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the PA's services are eligible for payment as assistant-at-surgery services. For additional policy requirements concerning assistant-at-

surgery services furnished by physicians and nonphysician practitioners, see chapter 12, section 20.4.3 of the Medicare Claims Processing Manual, pub. 100-04.

The *contractor* shall pay covered PA assistant-at-surgery services at *80 percent of the lesser of the actual charge or* 85 percent of *what a physician is paid under* the *Medicare P*hysician *F*ee *S*chedule. *Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.*

*T*he AS modifier must be *reported* on *the* claim *form when billing PA* assistant-at-surgery *services.*

110.*3* - Outpatient Mental Health Treatment Limitation

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

In general, *payment for covered PA services is made* at *80 percent of the lesser of the actual charge or* 85 percent *of what a physician is paid under* the Medicare Physician Fee Schedule. The *contractor* must apply the outpatient mental health treatment limitation (the limitation) to all covered mental health therapeutic services furnished by PAs.

Refer to §210 below for a complete discussion of the limitation.

110.*4* - PA Billing to *the Contractor*

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

A. **PA Identification**

PAs must have their own "*nonphysician practitioner*" *national* provider identification number *(NPI)* number. *This NPI is used for identification purposes only when billing for PA services, because only an appropriate PA employer or, a provider/supplier for whom the PA furnishes services as an independent contractor can bill for PA services*. Specialty code 97 applies *for PAs enrolled in Medicare*.

B. **Assignment Requirement**

All claims for PA services must be made on an assignment basis. If any person or entity (*PA* employer or, *a provider/supplier for whom the* PA *furnishes services as an independent contractor*) knowingly and willfully bills the beneficiary an amount in excess of the appropriate coinsurance and deductible, the responsible party is subject to a civil monetary penalty not to exceed $2,000 for each such bill or request for payment.

120 - Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services *Payment Methodology*

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

See *chapter 15, sections 200 and 210 of the Medicare Benefit Policy Manual, pub. 100-02,* for coverage policy *for NP and CNS services*.

A. General Payment

In general, NPs and CNSs are paid for covered services at *80 percent of the lesser of the actual charge or* 85 percent *of what a physician is paid under* the Medicare Physician Fee Schedule. *There is a separate payment policy for paying for NP and CNS assistant-at-surgery services. See section 120.1 of this chapter.*

B. Global Surgical Payments

When a NP or CNS furnish services to a patient during a global surgical period, contractors shall determine the level of NP or CNS involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims. NP or CNS services furnished during a global

surgical period shall be paid at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the Medicare Claims Processing Manual, pub. 100-04.

120.1 – Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that NPs and CNSs furnish as an assistant-at-surgery. Specifically, when a NP or CNS actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NP's and CNSs' services are eligible for payment as assistant-at-surgery services. For additional policy requirements concerning assistant-at-surgery services furnished by physicians and nonphysician practitioners, see chapter 12, section 20.4.3 of the Medicare Claims Processing Manual, pub. 100-04.

The *contractor* shall pay covered *NP and CNS* assistant-at-surgery services at *80 percent of the lesser of the actual charge or* 85 percent of the 16 percent *that a physician is paid under* the *Medicare P*hysician *F*ee *S*chedule. *Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that NPs and CNSs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.*

*Only t*he AS modifier must be *reported* on *the* claim *form when a NP or CNS bills* assistant-at-surgery *services*.

120.2 - Outpatient Mental Health Treatment Limitation

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

The *contractor* must apply the outpatient mental health treatment limitation (the limitation) to all covered mental health therapeutic services furnished by NPs and CNSs.
Refer to §210, below, for a discussion of the limitation.

120.3 – NP and CNS Billing to the Contractor

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

A. NP and CNS Identification

NPs and CNSs must have their own "nonphysician practitioner" national provider identification (NPI) number for billing purposes. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

B. Assignment Requirement

All claims for NP and CNS services must be made on an assignment basis. Payment may be made directly to a NP or CNS for their professional services when furnished in collaboration with a physician. If any person or entity (employer, NP or CNS) knowingly and willfully bills the beneficiary an amount in excess of the appropriate coinsurance and deductible, the responsible party is subject to a civil monetary penalty not to exceed $2,000 for each such bill or request for payment.

150 - Clinical Social Worker (CSW) Services

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

See Medicare Benefit Policy Manual, Chapter 15, for coverage requirements.

Assignment of benefits is required.
Payment is at 75 percent of the physician fee schedule.
CSWs are identified on the provider file by specialty code 80 and provider type 56.
Medicare applies the outpatient mental health limitation to all covered therapeutic services furnished by qualified CSWs. Refer to §210, below, for a discussion of the outpatient mental health limitation.

170.1 - Payment

(Rev.2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health treatment limitation (the limitation). Generally, the limitation does not apply to diagnostic services. Refer to §210 below for a discussion of the outpatient mental health treatment limitation.
Payment for the services of CPs is made on the basis of a fee schedule or the actual charge, whichever is less, and only on the basis of assignment.
CPs are identified by specialty code 68 and provider type 27.