
Medicare

Carriers Manual

Part 3 - Claims Process

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Services

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
2156 (Cont.) - 2160 (Cont.)	2-86.9 - 2-86.14 (6 pp.)	2-86.9 - 2.86.14 (6 pp.)
Chapter IV, Table of Contents	4-1 - 4-2 (2 pp.)	4-1 - 4-2 (2 pp.)
4112.1 - 4115	4-30.1 - 4-32 (6 pp.)	4-30.1 - 4-32 (6 pp.)
7553 (Cont.)	---	7-171 (1 p.)

MANUALIZATION--EFFECTIVE DATE: *Not Applicable*
--IMPLEMENTATION DATE: *Not Applicable*

The sections listed below are manualized to reflect the policy and instructions previously released in Program Memorandum AB-98-15 (CR 202), as it pertains to NPs and CNS' only. CMS intends to issue revised instructions for the coverage and payment of PA services in the near future.

Section 2156, Physician Assistant Services, is revised to include the definition of a physician assistant (PA) and coverage conditions of PA services after January 1, 1998.

Section 2158, Nurse Practitioner Services, is revised to include the definition of a Nurse Practitioner (NP) and coverage conditions and exclusions of NPs.

Section 2160, Clinical Nurse Specialist Services, is revised to include the definition of a Clinical Nurse Specialist (CNS) and coverage conditions and exclusions of CNSs.

Section 4112, Billing for Physician Assistant (PA), Nurse Practitioner (NP) Or Clinical Nurse Specialist (CNS) Services, is revised to remove the restriction of the areas an settings in which the services of PAs, NPs and CNSs are paid for by Medicare.

Section 4112.1, Billing Requirements for PA Services, is revised to include the payment requirements, employment relationship, services rendered in RHCs and FQHCs and modifiers for PA Services.

Section 4112.2, Billing Requirements for NP or CNS Services, is revised to include the payment requirements, services rendered in RHCs and FQHCs, and modifiers for PA Services.

Section 4113, Billing for SNF and NF Visits, is **deleted** and **replaced** by "Billing for Teaching Physician Services." Billing for Teaching Physician Services was erroneously placed in §4112.1.

Section 7553.I, Carrier Claims Requirements Monitoring Report, is **deleted** as the requirements for this report was discontinued 3 years ago.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CMS-Pub. 14-3

1. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians;
2. Has satisfactorily completed a program for preparing PAs that:
 - o Was at least 1 academic year in length;
 - o Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
 - o Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
3. Has satisfactorily completed a formal educational program for preparing PAs that does not meet the requirements of subsection A.2 and was assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding January 1, 1987.

B. Covered Services.--Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General.--The services of a PA may be covered under Part B, if all of the following requirements are met:

- o They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- o They are performed by a person who meets the definition of a PA (see subsection A);
- o They are performed under the supervision of an MD/DO;
- o They are performed in a hospital, SNF or NF, or as an assistant at surgery, or effective for services furnished on or after January 1, 1989, in a designated rural health professional shortage area (see §4500), regardless of the site of services; and
- o They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection B.4.)

2. Incident To.--If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in §2050.

3. Types of PA Services That May Be Covered.--State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. Consider developing lists of covered services.

Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting X-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

See §2050.3 for coverage of services performed by PAs incident to the services of physicians.

4. Services Otherwise Excluded From Coverage.--PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a PA's scope of practice under State law.

C. Physician Supervision.--The PA's physician supervisor (or a physician designated by the supervising physician or 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, unless State law or regulations provide otherwise. However, if the physician supervisor (or physician designee) is not physically present with the PA, he or she must be immediately available to the PA for consultation purposes by telephone or other effective, reliable means of communication.

D. Employment Relationship.--Payment for services of a PA may be made only to the actual employer of the PA. The employer may be a physician, medical group, professional corporation, hospital, SNF, or NF. There must be a valid employment arrangement, and the test to be used to determine its validity is the common law test of an employer-employee relationship. A group of PAs may not incorporate and bill for their services. An ambulatory surgical center is not an appropriate employer for these purposes.

2158. NURSE PRACTITIONER SERVICES

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he or she is legally authorized to furnish NP services in the State where the services are performed. NPs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the NP benefit.

Payment for NP services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for NPs.-- In order to furnish covered NP services, a NP must meet the conditions as follows:

1. Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
 - Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; **or**
2. Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

The following organizations are recognized national certifying bodies:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;

- National Certification Board of Pediatric Nurse Practitioners & Nurses;
- Oncology Nurses Certification Corporation; and
- Critical Care Certification Corporation.

3. NPs applying for a Medicare billing number for the first time on or after January 1, 2001, must meet the requirements as follows:

a. 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**

b. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

4. NPs applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

a. 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;

b. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; **and**

c. Possess a master's degree in nursing.

B. 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).

1. **General.**--The services of a NP may be covered under Part B if all of the conditions are met:

a. They are the types of services that are considered as physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);

b. They are furnished by a person who meets the NP qualifications (see subsection A);

c. The NP is legally authorized to furnish the services in the State in which they are performed;

d. They are furnished in collaboration with an MD/DO as required by State law (see subsection D); and

e. They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.)

2. **Types of NP Services That May Be Covered.**--State law or regulation governing an NP's scope of practice in the State in which the services are performed applies. Consider developing a list of covered services based on the State scope of practice. Examples of the types of services that NP's may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting X-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

3. Incident To.--If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §2050.

(See §2050.3 for coverage of services performed by NPs incident to the services of physicians.)

C. Services Otherwise Excluded From Coverage.--NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services, are precluded from coverage even though they may be within a NP's scope of practice under State law.

D. Collaboration.--Collaboration is a process in which a NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

E. Direct Billing and Payment.--Direct billing and payment for NP services may be made to the NP.

(NOTE: See §4112 for Billing Instructions.)

2160. CLINICAL NURSE SPECIALIST SERVICES

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a clinical nurse specialist (CNS) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish CNS services in the State where the services are performed. CNSs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the CNS benefit.

Payment for CNS services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for CNSs.-- In order to furnish covered CNS services, a CNS must meet the conditions as follows:

1. Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;

2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and

3. Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

B. Covered Services.—Coverage is limited to the services a CNS is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General.--The services of a CNS may be covered under Part B if all of the conditions are met as follows:

- a. They are the types of services that are considered as physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- b. They are furnished by a person who meets the CNS qualifications (see subsection A);
- c. The CNS is legally authorized to furnish the services in the State in which they are performed;
- d. They are furnished in collaboration with a MD/DO as required by State law (see subsection C); and
- e. They are not otherwise excluded from coverage because of one of the statutory exclusions. (See subsection B.3.)

2. 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. Consider developing a list of covered services based on the State scope of practice.

- Examples of the types of services that CNSs may furnish include services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their 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.

3. Incident To.--If covered CNS services are furnished, services and supplies furnished incident to the services of the CNS may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §2050.

(See §2050.3 for coverage of services furnished by CNSs incident to the services of a physician.)

C. Services Otherwise Excluded From Coverage.--CNS services may not be covered if they are otherwise excluded from coverage even though a CNS may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and routine physical checkups and services that are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the function of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a CNS's scope of practice under State law.

D. Collaboration.--Collaboration is a process in which a CNS 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 CNSs 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 CNS when the services are furnished or to make an independent evaluation of each patient who is seen by the CNS.

E. Direct Billing and Payment--Direct billing and payment may be made to the CNS.
(NOTE: See §4112 for Billing Instructions.)

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Instruct the referring independent laboratory to identify the performing laboratory on its bills. Through normal bill review and claims sampling, verify that independent laboratories comply with these instructions. Inform independent laboratories not in compliance of their responsibilities. Refer continued violations to your RO.

NOTE: This policy applies to both a hospital laboratory (whether leased or not) and an independent laboratory, as long as the reference laboratory is certified to perform the referred test.

(See §§2070.1 and 10-6 of the Coverage Issues Manual concerning Electrocardiographic Services.)

4110.4 Independent Laboratory Services to a Patient at Home or in an Institution.--When it is medically necessary for an independent laboratory to take an EKG tracing or to obtain a specimen from a patient in his home or an institution, payment may, under certain circumstances, be made. (See §5114.5 for determining the reasonable charges.)

Medical necessity for such services exists, for example, where a laboratory technician draws a blood specimen from a homebound or an institutionalized patient. A patient need not be bedridden to be homebound. (See §§2051.1 and 2070.1H respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

In addition to the usual information required on billing forms (including the name of the prescribing physician), all independent laboratory claims for such specimen drawing or EKG services prescribed by a physician should be appropriately annotated, e.g., "patient confined to home," "patient homebound" or "patient in nursing home, no qualified person on duty to draw specimen." Assure the validity of the annotation through scientific claims samples as well as through your regular bill review techniques. (This could be done by use of the information in your files, and where necessary, contact with the prescribing physician.)

If a physician requests an independent laboratory to obtain specimens in situations which do not meet, or without regard to whether they meet, the medical necessity criteria in §2070.1H, an educational contact with the prescribing physician is warranted and, where necessary, corroborating documentation obtained on claims until you are assured that the physician prescribes such services only when the criteria are met.

4110.5 Hospital Laboratory Services Furnished to Nonhospital Patients.--When a hospital laboratory performs a laboratory service for a nonhospital patient, (i.e., for neither an inpatient nor an outpatient) it bills its intermediary on the HCFA-1450. If you receive such claims, deny them.

4112. BILLING FOR PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP) OR CLINICAL NURSE SPECIALIST (CNS) SERVICES

Effective January 1, 1998, §4511 and §4512 of the Balanced Budget Act of 1997 removed the restriction on the type of areas and settings in which the professional services of NPs and CNSs are paid for by Medicare.

4112.1 Billing Requirements for PA Services.--

To enable you to determine reasonable charges, accumulate customary and prevailing charges for PAs by using the actual charges they make for their services. Until these charges are accumulated, calculate their payment based upon the prevailing charges you have established for non-specialist physicians. After January 1, 1992, use the appropriate fee schedule amounts. (See §16001 and 16002.)

For services performed in a hospital, limit the payment to 75 percent of the charges for comparable services furnished by a participating non-specialist physician in a hospital. This payment limit

applies to a PA in a hospital or in a rural Health Professional Shortage Area (HPSA). For all other covered services, prevailing charges cannot exceed 85% of the charges for comparable services performed by a non-specialist participating physician in a similar locality. This applies to a PA in a NF or SNF or in a rural Health Professional Shortage Area (HPSA).

If the actual charge for the PA service is less than the payment calculated on the basis of a percentage of prevailing charges, pay the actual charge.

Apply the prevailing charge limits as follows:

- o When a PA performs as an assistant-at-surgery, limit the prevailing charge to 65 percent of a participating assistant surgeon's prevailing charge;
- o For services prior to January 1, 1991, the assistant surgeon's prevailing charge is limited to 20 percent of the prevailing charge for the primary surgeon;
- o For services on or after January 1, 1991, the assistant surgeon's prevailing charge is limited to 16 percent of the prevailing charge for the primary surgeon;
- o For services prior to January 1, 1991, the PA's prevailing charge for assistant-at-surgery cannot exceed 13 percent (20% X 65%) of the prevailing charge, adjusted by the economic index, for the surgical procedure; and
- o For services on or after January 1, 1991, the PA's prevailing charge for assistant-at-surgery cannot exceed 10.4 percent (16% X 65%) of the prevailing charge, adjusted by the economic index, for the surgical procedure.

Use the procedure code to identify the surgical assistant services and the place of service code entered in item 24B of the HCFA-1500 to identify where it was performed. If the actual charge is less than the amount calculated based upon the percentage of prevailing charges, pay the actual charge.

For services subject to a Medicare limit based upon the prevailing charge, such as the outpatient limit, apply the PA limitation to the Medicare allowed charge after application of the limit. For example, an outpatient service which is subject to the outpatient limit has a prevailing charge of \$100, which results in an allowed charge of \$60 (\$100 x 60 percent) for the physician's service. The PA limitation is 75 percent of the \$60, or \$45.

NOTE: For services of PAs described above as based on the prevailing charges of non-specialist physicians, effective January 1, 1992, limit the payment to the appropriate percentage of the Medicare physician fee schedule. (See §§16001 and 16002.)

Pay only the employer of the PA. The employer of a PA may be a physician, medical group, professional corporation, SNF, NF or hospital. For this purpose, a rural area has the same meaning as it does under the prospective payment system, i.e., an area outside a metropolitan statistical area or New England County Metropolitan Area. Pay PA services only on an assignment basis. Deny unassigned claims.

Instruct billers to identify PA services as an assistant-at-surgery with the modifier "AS." Modifier "AN" identifies other PA services except for SNF and NF visits as a member of a team. See §4113 for additional billing instructions for PA visits to SNFs and NFs.

Follow Part 2, §5240, 4.0 to preclude duplicate payments of escalated payments as a result of both a PA or NP and a physician filing for services during a visit.

4112.2 Billing Requirements for NP or CNS Services.--

A. Payment for a NPs or CNSs Services.--

1. Effective January 1, 1998, payment for a NPs or CNSs services are made at the lesser of the actual charge or 85 percent of the physician fee schedule. For assistant at surgery services, payment equals 80 percent of the lesser of either the actual charge, or 85 percent of the physician fee schedule amount paid to a physician serving as an assistant at surgery. Also, effective January 1, 1998 there is no restriction on the setting that a NP or CNS may provide services.

2. Payment may be allowed for services furnished by a NP or CNS, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

A facility or other provider includes a hospital, SNF, NF, comprehensive outpatient rehabilitation facility (CORF), ASC, community health center (CMHC), rural health center (RHC), or federally qualified health center (FQHC).

B. NP or CNS Services Rendered in RHCs and FQHCs.--

1. Certain professional services furnished by NPs or CNSs in RHCs and FQHCs are included in the payment to the facility. Examples of services payable under the facility payment include: visit codes, surgeries, interpretations of diagnostic tests, and services and supplies incident to their professional services such as injectable drugs. Carriers must use this information in the processing of claims for NPs or CNSs where the place of service indicates a RHC or FQHC.

2. In situations, where carriers are denying the service because the payment to the facility covers the charges submitted to the carrier, use EOMB message 17.18, Payment for these services are made under Part A of Medicare. The provider must submit this bill to the Part A intermediary, or MSN 17.9, Medicare Part A/Part B pays for this service. The provider must bill the correct Medicare contractor. Use remittance advice: Claim adjust denial code 97 Payment is included in the allowance for the basic service/procedure with new line level remark code M97, Not paid to practitioner when provided in this place of service. Payment included in the reimbursement issued the facility.

C. Modifiers for NP & CNS Services.--

1. Assistant at Surgery services provided by a NP or CNS must be submitted with an AS modifier.

2. Effective April 1, 1999, HCFA will no longer require the use of modifiers for submitting a claim for a NP service with the exception of the AS modifier for reporting an Assistant at Surgery service.

NOTE: Services provided incident to physicians services and payable under §1861(s)(2)(A) of the Act are not affected by the ability of a NP to direct bill for their services.

4113. BILLING FOR TEACHING PHYSICIAN SERVICES.

Teaching Physicians who involve residents in providing care to their patients and seek payment for their physician services must comply with the policy governing teaching physicians contained in § 15016 of the Medicare Carriers Manual. Effective January 1, 1997, services rendered by the Teaching Physicians involving a resident in the care of their patients must be identified when submitting the claim on Form HCFA-1500.

A. Teaching Physician Services that Meet the Requirement for Presence During the Key Portion of the Service.-- In item 24d of Form HCFA-1500, the GC modifier must be entered by the physician for Teaching Physician Services rendered in compliance with all the requirements outlined in § 15016 of the Medicare Carriers Manual. Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service, and were immediately available during the other parts of the service.

B. Teaching Physician Services Under the Exception to the Requirement for Presence During the Key Portion of the Service.--Certain Teaching Physicians are allowed an exception to the above policy. The exception is for the requirement that the Teaching Physician be present during the key portion of the service. Teaching Physicians who meet the requirements in § 15016 outlined for the exception to this policy must provide their local carrier with an attestation that they meet the requirements.

Teaching Physician services being billed under the exception to the policy governing presence during the key portion of the service must be identified when submitting the Part B bill for Physician services. In Item 24d of Form HCFA-1500, enter the GE modifier for all Teaching Physicians

Services rendered under the exception to the policy requiring the presence of the Teaching Physician during the key portion of the service.

4114. BILLING PROCEDURES FOR MAXILLOFACIAL SERVICES

For dates of services January 1, 1996 and after, when the physician makes the prosthetic impression and constructs the prosthesis, the physician bills using CPT codes 21076 through 21089. In these instances, the cost of the prosthesis is included in the practice expense relative value units assigned to that specific CPT code. When a prosthetist or outside lab makes the prosthetic impression and constructs the prosthesis, the prosthetist/outside lab should bill the DMERC using the appropriate Level II HCPCS codes.

If the physician makes the prosthetic impression and a prosthetist or outside lab constructs the prosthesis, the physician bills using CPT code 21299 (unlisted craniofacial and maxillofacial procedure). Medical documentation must accompany the claim because of the use of an unlisted procedure code. The prosthetist or outside lab bills the DMERC using the Level II HCPCS codes.

Do not pay for both the CPT surgical code (other than 21299 for impression) and the Level II HCPCS code for these claims. The physician and the prosthetist/outside lab must bill separately for the procedures they have furnished.

4115. AMBULANCE SERVICES

You are responsible for processing ambulance service claims for non-hospital patients. The supplier uses Form HCFA-1491, Request for Medicare Payment - Ambulance.

Some items on Form HCFA-1491 may not be pertinent in some areas of the country. Instruct ambulance suppliers in your service area which items are essential for complete claims information. For example, in some areas an ambulance supplier only charges a base rate for specified services. In these instances, items 14, 15, and 16 are not completed.

Form HCFA-1491 contains the information necessary for you to perform the review described in §2125. Carefully review round trip ambulance services to outpatient dialysis facilities on a per visit basis for medical necessity. Deny claims for transportation to freestanding dialysis facilities for routine maintenance dialysis treatments.

When a beneficiary files a claim for ambulance services on Form HCFA-1491, the data required must accompany the claim. (See §3002.D about requesting ambulance suppliers to include this information on their office statements.) Corroborating evidence may be received in the form of a physician's bill for inpatient hospital or SNF visits.

(See §§3102B and 4105.5 regarding jurisdiction of suppliers with sales or rental outlets in multiple carrier service areas.)

4118. CHIROPRACTIC SERVICES

A. Verification of Chiropractor's Qualifications.--Establish a reference file of chiropractors eligible for payment as physicians under the criteria in §2020.26. Pay only chiropractors on file. Information needed to establish such files is furnished by the RO.

The RO is notified by the appropriate State agency which chiropractors are licensed and whether each meets the national uniform standards.

B. Durable Medical Equipment Regional Carriers Processing Claims When a Chiropractor is the Supplier.--Effective July 1, 1999, except for restrictions to chiropractor services as stipulated in §§1861(s)(2)(A) of the Social Security Act, chiropractors (specialty 35) can bill for durable medical equipment, prosthetics, orthotics and supplies if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse. In order to process claims, the Common Working File has been changed to allow specialty 35 to bill for services furnished as a supplier.

C. Documentation.--The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or date of exacerbation of the existing condition must be entered in Item 14 of Form HCFA-1500. (See §2010.2.) This serves as affirmation by the chiropractor that all documentation required as listed below and in §2251.2B is being maintained on file by the chiropractor.

1. Specification of the precise spinal location and level of subluxation (see §2251.4) giving rise to the diagnosis and symptoms.

2. Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes. Effective for claims with dates of service on or after October 1, 2000, when the x-ray is used to demonstrate subluxation, the date of the x-ray must be entered in Item 19 of the HCFA-1500 and the date must be within the parameters specified in §2251.2.

For claims with dates of service prior to January 1, 2000 and for claims with dates of service on or after October 1, 2000 for which an x-ray is still used to show subluxation, the following instructions on documentation apply: