

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11771	Date: December 30, 2022
	Change Request 13029

SUBJECT: Internet-Only Manual (IOM) Updates for Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update IOM Pub. 100-02, Chapter 15, and Pub. 100-08, Chapter 10, with the provision in the 2023 Physician Fee Schedule final rule regarding adding the Nurse Portfolio Credentialing Commission (NPCC) to the list of national certifying bodies for NPs and CNSs.

EFFECTIVE DATE: January 1, 2023

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 31, 2023

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	15/200 - Nurse Practitioner (NP) Services
R	15/210 - Clinical Nurse Specialist (CNS) Services

III. FUNDING:

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 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 11771	Date: December 30, 2022	Change Request: 13029
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SUBJECT: Internet-Only Manual (IOM) Updates for Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

EFFECTIVE DATE: January 1, 2023

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IMPLEMENTATION DATE: January 31, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to add the Nurse Portfolio Credentialing Commission (NPCC) to the list of national certifying bodies under the manual instructions at Chapter 15, section 200 for NPs and, section 210 for CNSs of the Medicare Benefit Policy Manual, Pub. 100-02. (Sections 10.2.3.5 and 10.2.3.8 in Chapter 10 of Pub. 100-08 are also being updated with the foregoing changes.) The CY 2023 Physician Fee Schedule final rule adds the NPCC to the list of recognized national certifying bodies for NPs and CNSs. Accordingly, effective January 1, 2023, NPs and CNSs who are certified by the NPCC meet the Medicare Part B program's national certification qualification requirement to enroll under the NP and CNS statutory benefit category.

B. Policy: The IOM Pub. 100-02, Chapter 15, and Pub. 100-08, Chapter 10, are being updated with the provision in the 2023 Physician Fee Schedule final rule regarding adding the NPCC to the list of national certifying bodies for NPs and clinical nurse specialists CNSs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
		13029 - 02.1	Contractors shall be aware of the updates listed in this CR for Chapter 15 of Pub. 100-02.	X	X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
13029 - 02.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Regina Walker-Wren, 410-786-9160 or regina.walkerwren@cms.hhs.gov (Payment Policy) , Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov (Provider Enrollment)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

200 - Nurse Practitioner (NP) Services

(Rev.11771 ; Issued:12-30-22 ; Effective:01-01-23 ; Implementation:01-01-23)

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

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

A. Qualifications for NPs

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

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

The following organizations are recognized national certifying bodies 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 (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation;
- National Board on Certification of Hospice and Palliative Nurses; *and,*
- *Nurse Portfolio Credentialing Commission.*

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

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

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

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

- Possess a master's degree in nursing or a doctor of nursing practice (DNP) doctoral degree.

B. Covered Services

Coverage is limited to the services an NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law).

1. General

The services of an NP may be covered under Part B if all of the following conditions are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets the definition of an NP (see subsection A);
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with an MD/DO (see subsection D); and
- They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)

2. Incident To

If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

3. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B nurse practitioner covered services, the nurse practitioner may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the nurse practitioner's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of NP Services That May Be Covered

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

See §60.2 for coverage of services performed by NPs incident to the services of physicians.

2. Services Otherwise Excluded From Coverage

The 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 an NP's scope of practice under State law.

D. Collaboration

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

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

E. Direct Billing and Payment

Direct billing and payment for NP services may be made to the NP.

F. Assignment

Assignment is mandatory.

210 - Clinical Nurse Specialist (CNS) Services

(Rev.11771 ; Issued:12-30-22 ; Effective:01-01-23 ; Implementation:01-01-23)

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 or a doctor of nursing practice (DNP) doctoral degree; and
3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

The following organizations are recognized national certifying bodies for CNSs 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 (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation;
- National Board on Certification of Hospice and Palliative Nurses; *and,*
- *Nurse Portfolio Credentialing Commission.*

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 following conditions are met:

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

2. Types of CNS Services that May be Covered

State law or regulations governing a CNS' scope of practice in the State in which the services are furnished applies. A/B MACs (B) must develop a list of covered services based on the State scope of practice.

Examples of the types of services that a CNS may furnish include services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of his or her State license, a CNS may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

3. Incident To

If covered CNS services are furnished, services and supplies furnished incident to the services of the CNS may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

4. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B Clinical Nurse Specialist (CNS) covered services, the CNS may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the CNS's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of CNS Services

Examples of the types of services that CNS may provide are services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. State law or regulation governing a CNS' scope of practice for his or her service area applies.

2. Services Otherwise Excluded From Coverage

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

See §60.2 for coverage of services performed by a CNS incident to the services of physicians.

D. Collaboration

Collaboration is a process in which a CNS works with one or more physicians (MD/DO) to deliver health care services within the scope of the CNS' professional expertise with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by the CNS documenting his or her scope of practice and indicating the relationships that the CNS has with physicians to deal with issues outside the CNS' scope of practice.

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

E. Direct Billing and Payment

A CNS may bill directly and receive direct payment for their services.

F. Assignment Requirement

Assignment is required for the service to be covered.