RBRVS Payment for Non-MD/DO Health Care Professionals

RUC Health Care Professionals Advisory Committee (HCPAC) Review Board

The RVS Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC) Review Board was formed in 1992 to allow for participation of non-MD/DO health care professionals in the RUC process. The 13 organizations currently seated on the HCPAC represent audiologists, chiropractors, marriage and family therapists, advanced practice registered nurses, occupational therapists, optometrists, physical therapists, physician assistants, podiatrists, psychologists, social workers, speech pathologists and registered dieticians.

All of these professionals use CPT® to report the services they provide independently to Medicare patients, and they are paid for these services based on the RBRVS physician payment schedule. The HCPAC members together with three physician members of the RUC comprise the RUC HCPAC Review Board, which is responsible for developing relative value recommendations which are submitted to CMS for new, revised and potentially misvalued codes that are reported principally by non-MD/DO professionals.

The co-chair of the HCPAC Review Board also serves as a member of the RUC. In addition, each of the HCPAC members serve on the RUC's subcommittees, workgroups and facilitation committees. These individuals are critical participants to both the HCPAC Review Board and the RUC processes.

Medicare Physician Payment Schedule (MFS)

The Medicare Physician Payment Schedule (MFS) provides separate coverage and payment for the following non-MD/DO health care professionals including:

- Audiologists
- Certified nurse midwives
- Certified registered nurse anesthetists
- Chiropractors
- Clinical psychologists
- Clinical social workers
- Dentists
- Marriage and family therapists and mental health counselors
- Nurse practitioners and clinical nurse specialists
- Occupational therapists
- Optometrists
- Physician assistants
- Physical therapists
- Podiatrists
- Registered dietitians
- Speech-language pathologists

As discussed in the next sections, the payment rules governing these services vary considerably according to such factors as site of service, medical supervision, and other circumstances.

Non-MD/DO Health Care Professionals

All carriers have implemented nationally standardized payment practices for non-MD/DO health care professionals by using CPT® codes for these services, where applicable; in all other instances, the appropriate Healthcare Common Procedure Coding System (HCPCS) code is maintained. Payment amounts for each non-MD/DO category will be calculated by carriers. Centers for Medicare & Medicaid Services (CMS) uses the specialty designation of these nonphysician practitioners to collect and analyze data on the services they provide.

Approved amount for non-MD/DO services under the payment schedule are tied to approved amount for physicians' services in the locality. That is, the payment schedule for non-MD/DO services is implemented in the same manner as the payment schedule for physicians' services. In the section that follows, therefore, the term "*payment schedule"* refers to the full Medicare payment schedule amount for a particular physician's service in the locality.

Chiropractors

CPT codes for chiropractic manipulative treatment (CPT codes 98940-98943) were introduced in CPT 1997. In assigning work RVUs to these services, CMS accepted the recommendation of the RUC HCPAC Review Board that these codes represented services and work essentially parallel to those of the osteopathic manipulation treatment (OMT) codes (CPT codes 98925-98929). Thus, the same RVUs were assigned to chiropractic manipulative treatment as for osteopathic manipulative treatment. In February 2011, RUC reviewed the OMT codes, which resulted in work RVUs increases. At that time, RUC and CMS agreed that there was compelling evidence that these services were based on flawed methodologies when established by Harvard. For CPT 2014, CMS again accepted the RUC recommendations that it is appropriate to crosswalk the CMT codes to the OMT codes. It is important to note that CPT code 98943 is not recognized for payment by Medicare.

Effective January 1, 2000, Medicare no longer required an X-ray to show a subluxation of the spine for coverage of treatment. Medicare now pays for chiropractic manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment.

Currently, Medicare reimburses three CPT codes provided by chiropractors: 98940 for manipulative treatment of 1–2 regions of the spine; 98941, manipulative treatment of 3–4 regions of the spine; and 98942, manipulative treatment of 5 regions of the spine. In the Final Rule for CY 2005, CMS implemented a two-year demonstration project authorized by the Medicare Modernization Act (MMA), to determine whether additional chiropractic services should be covered under Medicare, such as diagnostic and other services that a chiropractor is authorized to perform. This budget-neutral demonstration occurred at the following sites: Maine; New Mexico; Scott County, Iowa; 26 counties in Illinois; and 17 counties in central Virginia. This demonstration project ended March 31, 2007.

Physical/Occupational Therapists (PT/OTs)

The CPT codes for physical medicine services were substantially revised for the CPT 1995 and work RVU recommendations were developed according to RUC process. The 1995 work RVUs established for these codes represented the first time that work RVUs for physical medicine services had been based on the work associated with furnishing the service. Previously, work RVUs for the physical medicine codes were based on historic charges. CMS indicated in the 1995 Final Rule, however, that CPT codes 97545 and 97546 would continue to be carrier priced until better definitions for these services are developed.

The full range of CPT codes 97010 through 97799 may be reported by occupational and physical therapists in private practice, if the service is within the scope of practice. Payment for these services is made according to the Medicare payment schedule. Physical and occupational therapy services must be furnished as part of a written treatment plan, which the physician or therapist caring for the patient establishes, and the provider of the services must be qualified within the state's scope-of-practice laws.

A new CPT code was established for CPT 1999 to describe manual therapy techniques, including mobilization and manipulation. It was expected that the primary users of code 97140 would be physical and occupational therapists, as it was a better way to describe the spectrum of services they provide. This code was developed after two years of discussion by the Manual Therapy Techniques Workgroup, which recommended distinct coding nomenclature for osteopathic manipulative treatment (OMT), chiropractic manipulative treatment (CMT), and manual therapy techniques performed by physical therapists and occupational therapists. Code 97140 replaced five codes (97122, 97250, 97260, 97261, 97265).

Effective January 1, 1999, all outpatient rehabilitation therapy services were to be subject to an annual cap of $1500 per Medicare beneficiary according to the *Federal Register* published November 2, 1998. The cap would apply to all outpatient therapy except for therapy provided in hospital outpatient departments. The Balanced Budget Refinement Act placed a moratorium on Medicare Part B outpatient therapy caps until January 1, 2003. Litigation further delayed implementation.

In the Final Rule for CY 2002, CMS indicated that it would implement the outpatient rehabilitation therapy financial limitation via a program memorandum (AB-03-018) to carriers and fiscal intermediaries. Outpatient rehabilitation claims for services rendered on or after September 1, 2003, and before December 8, 2003, were subject to the payment limitation indexed to inflation at $1590 per year per patient.

The MMA, signed into law on December 8, re-established the moratorium on the therapy cap until December 31, 2005.

CMS announced in the Final Rule for CY 2005 that an annual, per beneficiary combined cap on outpatient physical therapy and speech-language pathology; and a separate annual cap on occupational therapy services performed under Medicare Part B would be implemented January 1, 2006. The original cap for 1999–2001 was set at $1500. It was determined that for years after 2001, the therapy cap would be equal to the preceding year's cap increased by the percentage increase in the MEI. It should also be noted that physical therapy services performed by chiropractors under the chiropractor demonstration project were subject to the therapy cap as well.

The Deficit Reduction Act (DRA) of 2005 initiated an exceptions process for beneficiaries who exceed the therapy cap. Medically necessary therapy services beyond the therapy cap could be obtained in two ways: an automated exception or a manual exception. The automated exception process required no specific or additional documentation, and no request was required on behalf of the beneficiary or provider. The automated exceptions process was designated using modifier KX to the claim. The manual exception process included a manual application, which required a written request by the beneficiary or provider for patients who did not qualify for an automated exception. This process used medical review by the CMS contractor responsible for processing the claim. Originally, this exception process was to be employed only in 2006, but the utilization of this process was extended several times through subsequent legislation. Specifically, as part of the Tax Relief and Health Care Act of 2006, it was extended through 2007. The process was again extended through June 30, 2008, by the Medicare, Medicaid, and SCHIP Extension Act of 2007, and again from July 1, 2008, through December 31, 2009, by § 141 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The Affordable Care Act extended the exception process from January 1, 2010, through December 31, 2010. The Medicare and Medicaid Extenders Act of 2010 extended the exceptions process from January 1, 2011, through December 31, 2011. An additional two-month extension, through February 29, 2012, was granted due to the Temporary Payroll Tax Cut Continuation Act of 2011. The exception process was extended through December 31, 2013, by the American Taxpayer Relief Act. Most recently, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017, and modified the requirement for manual medical review for services over the $3700 therapy thresholds. MACRA also extended the application of the therapy caps and related provisions to outpatient hospitals until January 1, 2018.

The Bipartisan Budget Act of 2018, effective January 1, 2018, repealed the application of the Medicare outpatient therapy caps and the therapy cap exceptions process while retaining and adding limitations to ensure therapy services are furnished when appropriate. The threshold process consists of two tiers: one for applying the KX modifier and one for a targeted medical review process. The KX modifier threshold is adjusted each year. After expenses for therapy service for the year have exceeded the therapy threshold amounts established for that year, providers must use the KX modifier on claims for subsequent services. Documentation should support the medical necessity of services over the threshold amount. A targeted medical review (MR) process (first established through MACRA at a threshold amount of $3700) may be initiated for claims submitted after the MR threshold has been reached. For 2018-2028, the targeted MR threshold amount is $3000. For more information on the manual medical review process, please visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review.

CMS implemented a multiple procedure payment reduction (MPPR) for therapy services that was scheduled to take effect beginning on January 1, 2011. This policy reduced payment by 25% for the practice expense (PE) component of the second and subsequent therapy services furnished to a patient on a single day of service. This policy was applied to all "always" therapy services, as defined by CMS. The Physician Payment and Therapy Relief Act of 2010 decreased the reduced payment to 20%. The American Taxpayer Relief Act of 2012 revised the MPPR on outpatient therapy services to reduce payment by 50% for the PE component of the second and subsequent therapy services, effective April 1, 2013.

The Bipartisan Budget Act of 2018 required payment for services performed entirely or partially by a therapy assistant at 85% of the MFS payment starting on January 1, 2022. CMS created two new payment modifiers, CQ and CO, to be used with the current physical therapy and occupational therapy modifiers. Modifier CQ identifies services furnished in whole or in part by a physical therapist assistant (PTA) and modifier CO identifies services furnished in whole or in part by an occupational therapy assistant (OTA). As finalized, the modifiers are to be used when a therapy assistant performs more than 10% of a service (a 10% "*de minimis* standard"). These two modifiers were required starting January 2020 and CMS began applying the 15 percent payment reduction to therapy services provided by PTAs (using modifier CQ) or OTAs (using modifier CO), as required by statute effective January 1, 2022. In addition, in the CY 2022 Final Rule, CMS finalized refinements to clarify the de minimis policy.

Requirements for these modifiers were revised and clarified in the CY 2020 Final Rule. Modifiers CQ and CO are not required when a therapy assistant is involved in a service provided by a physical or occupational therapist at the same time. These modifiers are applied at the unit level.

Starting in 2021, CMS permanently granted PTs and OTs the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a therapy assistant, either a PTA or an OTA. This policy allows PTs or OTs to use the same discretion to delegate therapy-services maintenance to PTAs or OTAs that they utilize for rehabilitative services.

Since 2005, CMS has required PTs and OTs in private practices (PTPPs and OTPPs, respectively) to provide direct supervision of their therapy assistants. In the CY 2024 Final Rule, CMS finalized a regulatory change to allow for general supervision of therapy assistants by PTPPs and OTPPs for remote therapeutic monitoring (RTM) services. In the CY 2025 Final Rule, CMS finalized a further regulatory change to allow for general supervision of PTAs and OTAs by PTPPs and OTPPs for all applicable physical and occupational therapy services. CMS now allows for general supervision of OTAs and PTAs by OTPPs and PTPPs, when the OTAs and PTAs are furnishing outpatient occupational and physical therapy services. CMS noted the licensure and patient safety protections that exist in this space and also commented that the majority of states allow OTs and PTs to provide general supervision of their respective OTAs and PTAs when furnishing occupational therapy and physical therapy services.

Starting in 2025, CMS also finalized amendments to the certification and recertification regulations and an exception to the physician/nonphysician practitioner (NPP) signature requirement for occupational therapy, physical therapy, and speech-language pathology established treatment plans for purposes of the initial certification in cases where a written order or referral from the patient's physician/NPP is on file and the therapist has documented evidence that the treatment plan was transmitted to the physician/NPP within 30 days of the initial evaluation. CMS amended the regulation at § 424.24(c) for those cases when a patient has a signed and dated order/referral from a physician/NPP for outpatient therapy services. CMS noted that a signed and dated order/referral from a physician/NPP combined with documentation of such order/referral in the patient's medical record, along with further evidence in the medical record that the therapy plan of treatment was transmitted/submitted to the ordering/referring physician or NPP, is sufficient to demonstrate the physician or NPP's certification of these required conditions. This is an exception to the initial certification and does not apply to recertification of therapy treatment plans.

Speech-Language Pathologists (SLPs)

Beginning July 15, 2008, speech-language pathologists (SLPs) are recognized by Medicare as independent practitioners who can bill for speech, language, voice, cognitive, communication, and swallowing evaluation and treatment services. Section 143 of the MIPPA of 2008 specified that SLPs may enroll independently as suppliers of Medicare services. Starting July 1, 2009, SLPs began independently reporting outpatient services they provide to Medicare patients. Amendments to §1848 of the Social Security Act do not create a separate targeted medical review threshold for speech-language pathology. The KX modifier threshold for speech-language pathology and physical therapy combined for 2025 is $2480 per beneficiary, and the threshold for targeted medical review is $3000. Services billed by SLPs may also be subject to the multiple procedure payment reduction (MPPR). See "Physical/Occupational Therapist" for a detailed discussion of the KX modifier and targeted medical review threshold, as well as MPPR.

Audiologists

In September 2006, audiology requested that CMS agree to consider establishing physician work relative values for services provided by audiologists. The specific request was that the professional work effort for audiologists providing these services be reflected in the work relative values, rather than in the PE relative values. CMS responded in November 2006 and indicated that they agreed to further consider this possibility. CMS advised RUC and HCPAC that if the committee recommends the use of work values for the audiology services, CMS would consider their recommendations. RUC reviewed and accepted consensus recommendations for nine audiology services. In the CY 2007 Final Rule, CMS assigned physician work RVUs to these nine audiology services. Audiology and otolaryngology used the work RVUs assigned to these services as reference points, when establishing work RVUs for the remaining audiology services, which were reviewed for the CPT 2011 cycle. New, revised, and potentially misvalued audiology services continue to be valued with work RVUs today. In the CY 2023 Final Rule, CMS revised §410.32(a)(4) to remove the order requirement under certain circumstances for certain audiology services furnished personally by an audiologist for non-acute hearing conditions (excludes balance assessments that are used for patients with disequilibrium) and created Modifier AB:

Modifier AB — *Audiology service furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary*

Modifier AB can be appended to 38 different CPT codes to identify services that are furnished without the order of a physician or nonphysician practitioner (NPP).

Physician Assistants (PAs)

The Balanced Budget Act of 1997 eliminated the Medicare requirement that physician assistants (PAs) practice under the direct, physical supervision of an MD/DO. The provision allows states to determine the required level of supervision. In the CY 2020 Final Rule, CMS revised regulations on physician supervision for physician assistant services, so that the statutory physician supervision requirement for PA services is met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. If there is no state law governing physician supervision of PA services, Medicare will require documenting at the practice level the PA's scope of practice and the working relationship the PA has with the supervising physician/s when furnishing professional services. Medicare authorizes coverage of PAs performing all levels of CPT evaluation and management codes, diagnostic tests, minor surgery, and other services if authorized under the scope of their State license. Medicare payment is lesser of the 85% of the Medicare RBRVS or the actual charge and does not vary by practice setting. A physician assistant must meet the following qualifications: (1) be licensed by the state to practice as a PA and (2) have graduated from PA program accredited by a recognized accrediting organization or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants.

PAs can maintain their relationships with physicians, but they can also be considered independent contractors of physicians. Payment would be the lower of the 85% of the Medicare RBRVS or the actual charge. Medicare payment would be the same regardless of practice location.

During the COVID-19 Public Health Emergency (PHE), CMS allowed NPs, CNSs, PAs, and CNMs to supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians. CMS made this updated supervision policy permanent for 2021 and beyond.

Effective January 1, 2022, CMS implemented the change from the Consolidated Appropriations Act, 2021 (section 403), which removed the requirement to make payment for PA services only to the employer of a PA and allowed PAs to work as independent contractors. This allowed PAs to bill the Medicare program, be paid directly for their services, reassign their rights to payment for their services, and incorporate as a group comprised solely of practitioners in their specialty and bill Medicare. This change impacts the statutory billing construct for PA services; however, it does not change the statutory benefit category for PA services, including the requirement that PA services are performed under physician supervision or collaboration and in accordance with state scope of practice laws, nor does it change the statutory payment percentage applicable to PA services.

Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

The Balanced Budget Act of 1997 also allows nurse practitioners (NPs) and clinical nurse specialists (CNSs) to practice without the direct, physical supervision of an MD/DO, and furthermore, allows these practitioners to receive direct Medicare payment. Medicare payment continues to be the lesser of the 85% of the Medicare RBRVS or the actual charge and does not vary by practice setting. However, as outlined in the CY 1998 Final Rule, beginning January 1, 1999, both NPs and CNSs must meet newly expanded certification requirements to be able to bill Medicare for their services.

A Nurse Practitioner must now meet the following qualifications: (1) Possess a master's degree in nursing; (2) Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a NP in accordance with state law, and; (3) Be certified as a nurse practitioner by the American Nurses Credentialing Center or other recognized national certifying bodies that have established standards for nurse practitioners.

Clinical Nurse Specialists must also meet similar qualifications to bill for Medicare Part B coverage of their services including: (1) Be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to perform 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.

The new rules in the CY 1998 Final Rule also outlined the policy for NPs and CNSs in states with no regulations on their collaboration with a physician(s), as such that "NPs and CNSs must document their scope of practice and indicate the relationships that they have with physicians to deal with issues outside their scope of practice."

In the CY 2009 Final Rule, CMS announced that Medicare will recognize advanced practice nurses with more extensive education and experience (ie, Doctor of Nursing Practice [DNP] doctoral degree, which can be obtained without a master's degree in nursing), while continuing to recognize NPs and CNSs with a master's degree in nursing. NPs or CNSs with a doctoral degree in nursing practice will not be denied enrollment in the Medicare program because of the educational standard of a master's degree for NPs and CNSs.

During the COVID-19 PHE, CMS allowed NPs, CNSs, PAs, and CNMs to supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians. CMS made this updated supervision policy permanent for 2021 and beyond.

Certified Nurse Midwives (CNMs)

Effective January 1, 1994, payment may be made for services provided by a certified nurse midwife (CNM) as authorized by state law, including obstetric and gynecologic services, if otherwise covered when provided by a physician. Beginning January 1, 2011, the Affordable Care Act mandated that nurse midwives be paid at 100% of the MFS amount. Services must be provided on an assignment basis.

During the COVID-19 PHE, CMS allowed NPs, CNSs, PAs, and CNMs to supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians. CMS made this updated supervision policy permanent for 2021 and beyond.

See Table 11-1 below for a summary of non-MD/DO health care professional payment policies.

Table 11-1. Nurse and Physician Assistant Payment

Practitioner	Medicare	Medicaid	Private Payers	Medicare Supervision Requirements
Nurse Practitioner (NP)	Pays 85% of the Medicare RBRVS, 100% if billed incident-to in a physician office or clinic	Pays in all states. Some states mandate payment at the physician rate. Some states pay at a reduced percentage of the physician rate.	Varies. Some states mandate payment at physician rate. Some payments made to the physician or employer. Twenty-nine states require insurers to reimburse directly.	Supervision requirements defer to state law for advance practice nurses. In most circumstances, NPs must collaborate with a physician, meaning that the NP works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided in jointly developed guidelines or other mechanism as defined by the law of the state in which the services are performed. They may supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.
Clinical Nurse Specialist (CNS)	Pays 85% of the Medicare RBRVS, 100% if billed incident-to in a physician office or clinic	Varies by state. CNSs treated as RNs in certain states and not eligible for reimbursement	Varies. Some states mandate payment at physician rate. Some payments made to the physician or employer. Thirty-seven states require insurers to reimburse directly.	Supervision requirements defer to state law for advance practice nurses. In most circumstances, CNSs must collaborate with a physician, meaning that the CNS works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided in jointly developed guidelines or other mechanism as defined by the law of the state in which the services are performed. They may supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.
Certified Nurse Midwife (CNM)	Pays 100% of the Medicare RBRVS	Pays in all states. Some states mandate payment at physician rate. Some states pay at a reduced percentage of the physician rate.	Varies. Some states mandate payment at physician rate. Some payments made to the physician or employer. Thirty-seven states require insurers to reimburse directly.	Supervision requirements defer to state law for advance practice nurses. CNMs may practice independently, but most state require some form of physician collaboration. They may supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.
Physician Assistant (PA)	Pays 85% of the Medicare RBRVS, 100% if billed incident to in a physician office or clinic	Pays in all states. Some states mandate payment at physician rate. Some states pay at a reduced percentage of the physician rate.	Varies. Payments are made to a PA. Nearly all private payers reimburse for services provided by PAs. Some states require private insurers to cover services performed by a PA.	Supervision requirements for PA services is met when a PA furnishes services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. They may supervise the performance of diagnostic tests, in addition to physicians, within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.

Certified Registered Nurse Anesthetists (CRNAs)

The same relative value scale (RVS) is used to determine payment for both physician anesthesia services and certified registered nurse anesthetist (CRNA) services. The conversion factor (CF) for a nonmedically directed CRNA will be limited to the anesthesia CF applicable in that locality. All services must be furnished on an assignment basis. Beginning in 1998, Medicare pays on a uniform basis for the provision of anesthesia services, whether performed by a physician alone or with a team. For 2013, CMS clarified the definition of the Medicare benefit category for CRNAs, as including any services the CRNA is permitted to furnish under their state's scope of practice. In addition, this action resulted in CRNAs being treated similarly to other advanced practice nurses for Medicare purposes. This policy is consistent with the Institute of Medicine's recommendation that Medicare cover services provided by advanced practice nurses to the full extent of their state scope of practice. "Anesthesia and related care" under the statutory benefit for CRNA services is defined as follows: "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." CMS will continue to monitor state scope of practice laws for CRNAs to ensure that they do not expand beyond the appropriate bounds of "anesthesia and related care" for purposes of the Medicare program. The aforementioned proposal does not address payment rates for anesthesiologists or CRNAs. The statutory provisions that establish payment rates for CRNAs at the same rate as anesthesiologists are relatively longstanding.

Clinical Psychologists

Medicare payment for diagnostic and therapeutic services provided by clinical psychologists was linked to the Medicare RBRVS payment schedule, effective January 1, 1997. Payment for such services is at 100% of the Medicare RBRVS. Previously, Medicare paid only for psychological testing services under the RBRVS payment schedule and paid for therapeutic services according to locality-based payment schedules determined by Medicare carriers. Diagnostic services provided by practitioners who do not meet the requirements for a clinical psychologist continue to be paid on a reasonable charge basis.

As part of the five-year review of the Medicare RBRVS, CMS developed 24 temporary HCPCS Level II codes for reporting psychotherapy services. These codes differentiate by the type of psychotherapy services provided, as well as the setting in which the service is furnished. They also allow psychotherapy services to be reported with and without medical evaluation and management services.

Only psychiatrists may perform and bill those codes that include medical evaluation and management. Clinical psychologists are not licensed to provide such services to Medicare patients, and therefore, may report only those codes involving nonmedical evaluation services. All services must be provided on an assignment basis. Diagnostic tests performed by an independently practicing psychologist (who is not a clinical psychologist) are paid, as are other diagnostic tests, if ordered by a physician. Clinical psychologist services, other than diagnostic services, furnished outside of the hospital inpatient setting are subject to the mental health services limitation (payment is limited to 62.5% of the payment schedule). However, beginning January 1, 2010, the limitation on recognition of expenses incurred for outpatient mental health services was phased out by increasing the Medicare Part B payment for outpatient mental health services to 80% by 2014. Beginning in 2014, Medicare started paying for outpatient mental health services at the same level as other Part B services.

Effective for CPT 1998, CPT codes for psychotherapy and psychological diagnostic testing replaced the HCPCS codes. The temporary HCPCS codes were crosswalked to the new CPT codes, as were the RVUs.

Beginning July 1, 2008, and ending December 31, 2009, MIPPA provided a 5% increase in the payment schedule for psychiatric therapeutic procedures, including insight oriented, behavior modifying, or supportive psychotherapy or interactive psychotherapy. This provision was extended by the Affordable Care Act from January 1, 2010–-December 31, 2010, and further extended by the Medicare and Medicaid Extenders Act of 2010, from January 1, 2011–-December 31, 2011.

Effective for CPT 2013, a new coding structure was created for psychotherapy services, following three years of effort by the CPT Editorial Panel, RUC, several national specialty societies, and health care organizations. The new coding framework allows all codes to be used in all settings, instead of describing site-specific services. Psychotherapy is now being reported with either stand-alone codes without medical services (CPT codes 90832, 90834, and 90837) or with add-on codes, which are used only in conjunction with E/M services (90833, 90836, and

90838). When a medical service is provided with psychotherapy, the appropriate E/M service should be reported and then an add-on psychotherapy time-based code (30, 45, or 60 minutes) will be reported. For 2013, CMS assigned interim relative values for these services and requested that RUC review add-on codes for the interactive component of psychotherapy and for crisis services, before the full review of the recommendations for the entire family of psychotherapy services. For 2014, RUC submitted the remaining interactive complexity component add-on codes for psychotherapy and crisis services. CMS accepted 100% of the RUC recommendations for the psychotherapy services for 2014, leading to $150 million in improved payments for these services each year. Medicare payments for psychiatrists, psychologists and clinical social workers were expected to increase 6-8% for CY 2014.

For CY 2024, CMS established new HCPCS codes for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit). Further, the payment amount for psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 *Psychotherapy for crisis; first 60 minutes* and 90840 *Psychotherapy for crisis; each additional 30 minutes — List separately in addition to code for primary service,* and any succeeding codes.

For CY 2025, CMS adopted three codes, G0552-G0554, for digital mental health treatment devices furnished under a behavioral health treatment plan of care. It also adopted six HCPCS codes that parallel the existing CPT codes for interprofessional consultations for use by certain non-MD/DO mental health professionals who CMS says cannot report the CPT codes with the goal of better integrating behavioral health treatment into primary care and other settings.

Licensed Clinical Social Workers (LCSW)

The distinction that applies to clinical psychologists regarding diagnostic and therapeutic services is also applicable to clinical social workers. Payment for licensed clinical social worker (LCSW) therapeutic services will be limited to 75% of the clinical psychologist payment schedule amount, while payment for diagnostic services will be according to the MFS.

Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

Beginning on January 1, 2024, CMS implemented payment under the MFS for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. Further, addiction counselors and drug and alcohol counselors who meet the applicable requirements to be an MHC are eligible to enroll in Medicare as MHCs. MFT and MHC services will be paid 80% of the lesser of the actual charge for the services or 75% of the amount determined for payment of a psychologist.

CMS defines “marriage and family therapist services” and “mental health counselor services” as services furnished by an MFT/MHC for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT/MHC is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.

It is important to note that most HCPCS codes do not specify in the code descriptor which practitioners may furnish the service described, so CMS need not change code descriptors for most codes describing services for the diagnosis and treatment of mental illnesses in order for MFTs and MHCs to bill for them. However, CMS updated the descriptor of the principal illness navigation service G0023 to explicitly include MFTs and MHCs. Additionally, on January 1, 2024, CMS will allow Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. Further, CMS added MFTs and MHCs to the list of practitioners who are eligible to furnish Medicare telehealth services at the distant site.

Registered Dietitians (RDs)

Section 105 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 created a benefit for medical nutrition therapy (MNT) for certain Medicare patients who have diabetes or a renal disease. This benefit was implemented on January 1, 2002. Medicare Part B will pay for MNT services furnished by a registered dietitian (RD) or nutrition professional when the beneficiary is referred for the service by the beneficiary's "treating physician." The *treating physician* is defined as the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease. The statute specifies that the Medicare payment for MNT services must equal 80% of the lesser of the actual charge for the services, or 85% of the amount determined under the MFS for the same services, if furnished by a physician. The MNT services should be reported using CPT codes 97802-97804. CMS also clarified that medical nutrition therapy cannot be provided incident to a physician's service unless the physician also meets the qualifications to bill Medicare as a registered dietitian or nutrition professional.

CMS proposed in the CY 2005 Final Rule to add individual medical nutrition therapy (HCPCS/CPT Codes G0720, 97802, and 97803) to the list of Medicare telemedicine services. Accordingly, because registered dietitians and nutrition professional are the primary providers of these services, they have been added to the list of providers who can receive payment for telemedicine services.

In the CY 2006 Final Rule, CMS announced that it will establish work RVUs for the medical nutrition therapy codes as recommended by RUC HCPAC for the CY 2001 Final Rule. This action comes after much lobbying from the AMA and the Academy of Nutrition and Dietetics (formerly American Dietetic Association).

In early 2008, CMS requested that the services described by CPT codes 97802 and 97803 be given the opportunity for consideration under the RUC process to help ensure that CMS payment for MNT services to non-MD/DO nutrition professionals is accurate. In the CY 2008 Final Rule, CMS announced it accepted the new work RVUs for these services as recommended by RUC for the 2009 MFS. CMS has priced the work, PE, and professional liability insurance (PLI) RVUs for MNT services as if they were performed by a physician. When registered dietitians perform these services, they are paid 85% of the amount that a physician performing these services would be paid.

In the CY 2024 Final Rule, CMS finalized an amendment to the regulatory provision that was established during CY 2022 rulemaking regarding diabetes self-management training (DSMT) furnished by RDs and nutritional professionals. The clarification states that an RD or nutrition professional must personally perform MNT services, but the enrolled RD or nutrition professional, when acting as the DSMT certified provider, may bill for, or on behalf of, the entire DSMT entity, regardless of which professional personally delivers each aspect of the services.

Medicare Physician Payment Schedule (MFS) Changes

In the CY 2026 Final Rule, CMS finalized an "efficiency adjustment" to the work RVU's for non-timed based services that the agency expects to accrue gains in efficiency over time. To determine this efficiency adjustment, CMS used the Medicare Economic Index (MEI) productivity adjustment percentage. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and with a look-back period of five years, the efficiency adjustment was finalized at -2.5% for CY 2026. This applies to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM. It is important to note that many of the services reported by non-MD/DO health care professionals are not impacted by the efficiency adjustment.

Resources

- AMA RUC HCPAC Review Board
- RUC & RUC HCPAC Review Board Recommendations

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