§ 414.56 Payment for nurse practitioners' and clinical nurse specialists' services.

(a) Rural areas. For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a rural area (as described in section 1861(s)(2)(K)(ii) of the Act) may not exceed the following limits:

1. For services furnished in a hospital (including assistant-at-surgery services), 75 percent of the physician fee schedule amount for the service.
2. For all other services, 85 percent of the physician fee schedule amount for the service.

(b) Non-rural areas. For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed 85 percent of the physician fee schedule amount for the service.

(c) Beginning January 1, 1998. For services (other than assistant-at-surgery services) furnished beginning January 1, 1998, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount for the service.

(d) January 1, 1999. For services furnished beginning January 1, 1999, allowed amounts for the services of a nurse practitioner or clinical nurse specialist for services furnished under the physician fee schedule if the assistant-at-surgery service were furnished by a physician.

§ 414.60 Payment for the services of CRNAs.

(a) Basis for payment. The allowance for the anesthesia service furnished by a CRNA, medically directed or not medically directed, is based on allowable base and time units as defined in §414.66(a). Beginning with CY 1994—

1. The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days by the patient’s admitting physician or practitioner), subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days by the patient’s admitting physician or nonphysician practitioner), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one “hands on” visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training services (except for one hour of “hands on” services to be furnished in the initial year training period to ensure effective injection training), individual and group health and behavior assessment and intervention, smoking cessation services, alcohol and/or substance abuse and brief intervention services, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression in adults, screening for sexually transmitted infections (STIs) and high intensity behavioral
counseling (HIBC) to prevent STIs, intensive behavioral therapy for cardiovascular disease, and behavioral counseling for obesity furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) Emergency department or initial inpatient telehealth consultations. The Medicare payment amount for emergency department or initial inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to initial hospital care provided by a physician or practitioner.

(ii) Follow-up inpatient telehealth consultations. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

(2) The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

(b) To whom payment may be made. Payment for an anesthesia service furnished by a CRNA may be made to the CRNA or to any individual or entity (such as a hospital, critical access hospital, physician, group practice, or ambulatory surgical center) with which the CRNA has an employment or contract relationship that provides for payment to be made to the individual or entity.

(c) Condition for payment. Payment for the services of a CRNA may be made only on an assignment related basis, and any assignment accepted by a CRNA is binding on any other person presenting a claim or request for payment for the service.

§ 414.62 Fee schedule for clinical psychologist services.

The fee schedule for clinical psychologist services is set at 100 percent of the amount determined for corresponding services under the physician fee schedule.

§ 414.63 Payment for outpatient diabetes self-management training.

(a) Payment under the physician fee schedule. Except as provided in paragraph (d) of this section, payment for outpatient diabetes self-management training is made under the physician fee schedule in accordance with §§ 414.1 through 414.48.

(b) To whom payment may be made. Payment may be made to an entity approved by CMS to furnish outpatient diabetes self-management training in accordance with part 410, subpart H of this chapter.