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Medicare Changes Impacting Clinical Nurse Specialists

Home Health

As a result of the Affordable Care Act, clinical nurse specialists, along with nurse practitioners and physicians, may certify home health services. Prior to this, CNSs did not have the authority to order home health services for their patients. The new mandate also requires the certifying practitioner to have a face-to-face encounter with the patient. The CNS must be working in collaboration with a physician and have seen the patient within 90 days prior to the start of the home health services. If the services are for a new condition, then the face-to-face encounter must occur within 30 days. This new authority for CNS will become effective on January 1, 2011.

The following were included in the final rule for Calendar Year 2011 Physician Fee Schedule, Effective 1/1/11:

Primary Care Services

The regulations implement incentive payments for primary care services, including those provided by **clinical nurse specialists**. At least 60 percent of the practitioner's allowed charges must be for primary care services. Beginning on January 1, 2011 primary care practitioners will be paid on a quarterly basis an additional10% of the payment amount for the primary care services provided in that quarter.

Telehealth Services

In the same final rule, CMS will pay **clinical nurse specialists** for telehealth services provided including the following: Initial inpatient consultations, follow-up inpatient consultations, office or other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, End Stage Renal Disease (ESRD) related services, individual medical nutrition therapy (MNT), neurobehavioral status exam, individual health and behavior assessment and intervention.

A practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system. Distant site practitioners must submit the appropriate HCPCS procedure code for a covered professional telehealth service, appended with the -GT (Via interactive audio and video telecommunications system) or –GQ (Via asynchronous telecommunications system) modifier. By reporting the –GT or –GQ modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at a telehealth originating site when the telehealth service was furnished.

Certification of SNF Care
Clinical nurse specialists, as well as nurse practitioners and physician assistants, may certify and recertify patients for SNF care, as long as they do not have a direct or indirect employment relationship with the facility and are working in collaboration with a physician. Prior to the issuance of this rule, clinical nurse specialists did not have this authority.

ESRD and Dialysis

With regard to conditions for coverage for dialysis facilities the regulations specify that a physician, nurse practitioner, clinical nurse specialist, or physician's assistant provide ESRD care at least monthly to all dialysis patients. The visit may be conducted in the dialysis facility, at the physician's office, or in the patient's home. The guidelines state that "any patient may choose not to be seen by a physician every month" but also specifies that if there is a pattern of a patient consistently missing physician and or practitioner visits, the lack of medical oversight should be addressed with the patient in the plan of care.

Annual Wellness Visit (AWV)

As a result of the Affordable Care Act a new benefit has been developed for an "annual wellness visit" (AWV) with personalized prevention plan services. A single payment would be made when an AWV is furnished by a physician, physician assistant, nurse practitioner, or **clinical nurse specialist**, or by a medical professional or team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

CMS has developed two new HCPCS G-codes for reporting the first wellness visit and creation of a personalized prevention plan and the subsequent visits available to the beneficiary every 12 months. Specifically, we proposed to establish the following two new HCPCS codes for CY 2011: GXXXA (AWV; includes a personalized prevention plan of service (PPPS), first visit) and GXXXB (AWV; includes a personalized prevention plan of service (PPPS), subsequent visit). A beneficiary's first AWV to any practitioner would be reported to Medicare under HCPCS code GXXXA, even if the beneficiary had previously received an initial preventive physical examination (IPPE) that was covered by Medicare. Beneficiaries, in their first 12 months of Part B coverage, would continue to be eligible only for an IPPE. After the first 12 months of Part B coverage, on or after January 1, 2011, beneficiaries would be eligible for an AWV described by HCPCS code GXXXA or GXXXB, provided that the beneficiary has not received an IPPE or AWV within the preceding 12-month period.