Non-Physician Medical Practitioners (NMP)

Page updated: September 2020

Services rendered by Non-Physician Medical Practitioners (NMPs) are covered by Medi-Cal. NMPs consist of Physician Assistants (PAs), Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs). The following information does not detract from the fact that CNMs and NPs (family and pediatric specialties) can enroll as free-standing individual providers and provider groups or as NMPs. For additional help, refer to the Non-Physician Medical Practitioners (NMP) Billing Example section of this manual.

Authorization Form Signatures

PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and subject to the following:

- Authority has been delegated by the supervising physician to provide the covered benefit or service pursuant to their scope of practice.
- The supervising physician and PA/NP/CNM are both enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7, Part 3 of Division 9 of the Welfare and Institutions Code (W&I Code).

PAs, NPs or CNMs may not sign authorization forms for the following covered benefits and services due to restrictions in Title 42 of Code of Federal Regulations Section 440.70 for home health services, Section 418.00 for hospice care or any other federal restriction for Medicaid. Restrictions include the following benefits and services:

- For hospice care, a physician’s authorization is required for patient certification (at the beginning of the first 90-day period) and recertification (at the beginning of each subsequent period of care) of terminal illness.
- For home health services, a physician’s authorization is required for durable medical equipment, medical supplies, enteral nutrition and other medical services provided through home health agencies, such as physical therapy, occupational therapy, speech pathology and audiology services.

Physician Assistants

Physician Assistants (PAs) are Non-Physician Medical Practitioners (NMPs) that are approved by the Medical Board of California to perform direct patient care services under the supervision of a licensed physician. PAs are employed by a Medi-Cal provider but are never an independent Medi-Cal provider.

Supervision Requirements

The services of PAs may be billed to Medi-Cal only if the following criteria are satisfied.
Physician Supervision

Services rendered by a PA must be performed under the general supervision of a physician. The physician may be engaged in private practice or may be a member of the medical staff of a hospital outpatient department, an outpatient clinic with surgical facilities or a community clinic. The supervising physician must be available to the NMP in person or through electronic means to provide:

- Supervision to the extent required by California professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral for appropriate care by specialist physicians or other licensed health care professionals

Patient Awareness

Medi-Cal providers who employ or use the services of PAs must ensure that each patient is initially informed that he/she may be treated by an NMP.

Physician/Practitioner Interface

Medi-Cal providers who employ or use the services of NMPs are required to develop a system of collaboration and physician supervision with each PA. The physician/practitioner interface document establishes the means by which medical treatment services provided by physicians and PAs are integrated and made consistent with accepted medical practice. This document must be kept on file at the provider’s office, readily available for review by the Department of Health Care Services (DHCS).

The Medi-Cal program also has specific requirements for the physician/practitioner interface document:

- In the case of PAs, guidelines are required by Business and Professions Code, Sections 3502, 3502.1, 3516 and 3516.5, and by Welfare and Institutions Code (W&I Code), Section 14132.966
- All written protocols issued in collaboration between the physician and the PA
- All written standing orders of the physician
Number Limitation of PAs Physician May Supervise

A single physician is limited to supervising four PAs (full-time equivalents).

- The supervising physician and surgeon shall review, countersign and date a sample consisting of, at minimum, 5 percent of the medical records of patients treated by the PA functioning under the protocols within 30 days of the date of treatment by the PA.

- If the PA ordered Schedule II drugs, the medical records must be reviewed, countersigned and dated by a supervising physician and surgeon within seven days.

A physician, an organized outpatient clinic, or a hospital outpatient department must not use more PAs than can be supervised within the limits previously stated.

PA Enrollment

PAs must be enrolled with the DHCS Provider Enrollment Division (PED) for Medi-Cal reimbursement. The PA and employing provider must enroll with PED via the Provider Application and Validation for Enrollment (PAVE) portal on the DHCS website (www.dhcs.ca.gov) with the following information:

- Uploaded copy of license issued by the Medical Board of California for PAs
- Uploaded copy of the supervising physician’s certificate issued by the Medical Board of California
Billing and Reimbursement

Reimbursement for services rendered by a PA can be made only to the employing physician, organized outpatient clinic or hospital outpatient department. Payment is made at the lesser of the amount billed or 100 percent of the amount payable to a physician for the same service. No separate reimbursement is made for physician supervision of a PA.

The supervising physician’s provider number must be entered as the rendering physician’s on each applicable claim line. Do not identify the PA as the rendering provider on the claim line. Instead, include the PA name, provider number and type of NMP-PA in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim.

Covered Services

Covered services for PAs include services performed by a PA within the scope of practice when the services would be a covered benefit if performed by a physician and surgeon. PAs may not prescribe durable medical equipment (DME). DME items require a written prescription (or electronic equivalent) from a physician.

Modifiers:

Providers must indicate the appropriate PA modifier in conjunction with the HCPCS or CPT® code when the service was performed by a PA. In addition to this PA modifier, the modifier codes in the Modifiers: Approved List section of this manual also may apply to PA services creating a multiple modifier condition.

The following modifiers identify PA services on the claims submitted.

<table>
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<tr>
<th>HCPCS Modifier</th>
<th>Definition</th>
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<tr>
<td>U7</td>
<td>Medicaid level of care 7, as defined by each state. Used to denote services rendered by PA.</td>
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<tr>
<td>99</td>
<td>Multiple Modifiers</td>
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Multiple Modifier Codes

If a multiple modifier code is needed to further define PA services, providers use the following modifier as appropriate to the type of PA service rendered.

"Multiple Modifier for PA Services Rendered"

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<th>HCPCS Modifier</th>
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<td>Multiple Modifiers</td>
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This modifier is entered in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim, in addition to any applicable modifiers, including U7 for PA services.

Modifier 99 – Billing Examples

In this first example, a physician assistant bills for an initial comprehensive antepartum office visit (HCPCS code Z1032), which occurred within 16 weeks of the patient’s last menstrual period. The provider enters code Z1032-99 in the Procedures, Services or Supplies field (Box 24D). In the Remarks field (Box 80)/Additional Claim Information field (Box 19) section of the claim, document:

99 = U7 + ZL

In this second example, a physician assistant performs as an assistant surgeon in a total hip replacement, CPT code 27130. On the claim line, the provider bills code 27130-99. In the Remarks field (Box 80)/Additional Claim Information field (Box 19) section of the claim, document:

99 = U7 + 80
Nurse Practitioner

A Nurse Practitioner (NP) is a Non-Physician Medical Practitioner (NMP) that is a licensed Registered Nurse (RN) legally entitled to use the title of NP. NPs predominantly practice “primary care” after completing a clinical and didactic educational program of at least six months’ duration, which is appropriate to the scope and function of the practitioner’s area of practice.

Note: The clinical and didactic educational program must have been completed in a college or university that offers a baccalaureate or higher degree, or in a health care agency that has an academic affiliation with such a college or university.

The Certified Nurse Practitioner (CNP) that is an independent Medi-Cal provider is discussed under “Nurse Practitioner Board Certified Specialty” in this section.

Primary Care Defined

Primary care is defined as health professional services provided in a continuing relationship established with an individual or family group. Primary care includes:

- Surveillance of health needs
- Access to comprehensive health care
- Referral to other health professionals
- Health counseling and patient education

Supervision Requirements

The services of NPs may be billed to Medi-Cal only if the following criteria have been satisfied.

Physician Supervision

Services rendered by an NP must be performed under the general supervision of a physician. The physician may be engaged in private practice or may be a member of the medical staff of a hospital outpatient department, an outpatient clinic with surgical facilities or a community clinic. The supervising physician must be available to the NP in person or through electronic means to provide:

- Supervision to the extent required by California professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral for appropriate care by specialist physicians or other licensed health care professionals

Part 2 – Non-Physician Medical Practitioners (NMP)
Patient Awareness

Medi-Cal providers who employ or use the services of NP must ensure that each patient is initially informed that he or she may be treated by an NMP.

Physician/Practitioner Interface

Medi-Cal providers who employ or use the services of NPs are required to develop a system of collaboration and physician supervision with each NP. The physician/practitioner interface document establishes the means by which medical treatment services provided by physicians and NPs are integrated and made consistent with accepted medical practice. This document must be kept on file at the provider's office, readily available for review by DHCS.

The Medi-Cal program also has specific requirements for the physician/practitioner interface document:

- In the case of RNs, standardized procedures as required by California Code of Regulations (CCR), Title 16, Article 7, Chapter 14, commencing with Section 1470
- All written protocols issued in collaboration between the physician and the NP
- All written standing orders of the physician

Number Limitation of NPs Physician May Supervise

There is no limit to the number of NPs that a single primary care physician may supervise, except as follows:

- For the purpose of furnishing or ordering of drugs or devices by an NP, no physician will supervise more than four at a time. The NP furnishes or orders drugs or devices in accordance with standardized procedures or protocols under the supervision of a physician who has current practice or training in the relevant field. Such supervision does not require the physical presence of the physician.

A physician’s co-signature or countersignature is not required for care provided by NPs. NPs must practice in collaboration with a physician who has current practice or training in the field in which the NP is practicing.

DHCS reserves the right to impose utilization controls and sanctions on NPs as authorized under applicable federal and state statutes and regulations. Nurses determined by DHCS to have abused the Medi-Cal program or furnished drugs or devices outside of the collaborating physician’s field of expertise are subject to the utilization restrictions, which may include, but are not limited to, the requirement of a countersignature by a supervising physician.
NP Enrollment

NPs must be enrolled with the DHCS Provider Enrollment Division (PED) for Medi-Cal reimbursement. The NP and employing provider must enroll with PED via the Provider Application and Validation for Enrollment (PAVE) portal on the DHCS website (www.dhcs.ca.gov) with the following information:

- Uploaded copy of license issued by the California Board of Registered Nursing or NPs
- Uploaded copy of certification as an NP

Billing and Reimbursement

Reimbursement for services rendered by an NP can be made only to the employing physician, organized outpatient clinic or hospital outpatient department. Payment is made at the lesser of the amount billed or 100 percent of the amount payable to a physician for the same service. No separate reimbursement is made for physician supervision of an NP.

The supervising physician’s provider number must be entered as the rendering physician on each applicable claim line. Do not identify the NP as the rendering provider on the claim line. Instead, include the NP name, provider number and type of NMP-NP in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim.
Covered Services

The following HCPCS, CPT and Medi-Cal-only codes describe primary care physician services that are covered by Medi-Cal when performed by an NP to the extent permitted by applicable professional licensing statutes and regulations as set forth in the Physician/Practitioner Interface. The HCPCS and CPT Medi-Cal-approved modifier codes may be used with these procedures as applicable.

Evaluation and Management

**CPT Codes**

- **G0442**
- **H0049**
- **H0050**

**HCPCS Codes**

- **G9919**
- **G9920**
- **H0049, H0050**

**Non-Specialty Mental Health Services**

**CPT Codes**

- **90785**
- **90791**
- **90792**
- **90832 thru 90834**
- **90836 thru 90840**
- **90846, 90847**
- **90849**

**HCPCS Codes**

- **G0442**
- **G9919**
- **G9920**
- **H0049, H0050**
### General Medicine

#### CPT Codes

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Pathology (includes immunology and hematology)

CPT Codes

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Health and Behavior Assessment/Intervention

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HCPCS Codes

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Dialysis

HCPCS Codes

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Part 2 – Non-Physician Medical Practitioners (NMP)
Surgery (includes contraceptive, obstetrics, gynecology and maternal care services)

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Surgery (includes contraceptive, obstetrics, gynecology and maternal care services, continued)

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Part 2 – Non-Physician Medical Practitioners (NMP)
Injections/Vaccines (continued)

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**Note:** Refer to the General Medicine, CPT codes listing on a following page in this section for codes within these ranges that are reimbursable to CNMs.
Non-Injectable Drugs

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Drugs Administered Other than Oral Method (includes contraceptive implants)

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The preceding covered services are the only physician service codes that are reimbursable when performed by an NMP within the scope and limitations of his or her practice. Services ordered by an NMP, with the exception of prescription drugs and durable medical equipment, are covered to the same extent as if ordered by a physician.
Modifiers

Providers must indicate the appropriate NP modifier in conjunction with the HCPCS or CPT code when the service was performed by an NP. In addition to these NP modifiers, the modifier codes in the Modifiers: Approved List section of this manual may also apply to NP services, creating a multiple modifier condition.

The following modifiers identify NP services on the claims submitted.

**Modifiers for NP Services on Claims Submitted**

<table>
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<th>HCPCS Modifier</th>
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<td>Multiple modifiers</td>
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Multiple Modifier Codes

If a multiple modifier code is needed to further define NP services, providers use the following modifier as appropriate to the type of NP service rendered.

**Modifier for Type of NP Service Rendered**

<table>
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<th>HCPCS Modifier</th>
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<td>Multiple modifiers</td>
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</table>

This modifier is entered in the Remarks field (Box 80)/ Additional Claim Information field (Box 19) of the claim, in addition to any applicable modifiers, including SA for Nurse Practitioner services.

Modifier 99 – Billing Example

In this billing example, a nurse practitioner sees a patient for an initial comprehensive antepartum office visit (HCPCS code Z1032), which occurred within 16 weeks of the patient’s last menstrual period. The provider enters code Z1032-99 in the Procedures, Services or Supplies field (Box 24D). In the Remarks field (Box 80)/ Additional Claim Information field (Box 19) section of the claim, document:

99 = SA + ZL
**Nurse Practitioner Board Certified Speciality**

**Certified Nurse Practitioner Provider**

Certified Nurse Practitioners (CNPs) are permitted to render services as independent practitioners and become Medi-Cal providers.

**Participation Requirements**

To qualify as an independent practitioner, participants must be:

- Licensed as a nurse and certified as a Nurse Practitioner by the California Board of Registered Nursing
- Nationally board certified
- Enrolled as an independent provider in the Medi-Cal program

**Provider Enrollment**

CNP participants must apply to the DHCS Provider Enrollment Division to bill Medi-Cal directly.

**Group Practice/ Rendering Provider Numbers**

CNPs involved in a group practice may bill Medi-Cal under a group practice provider number by enrolling in the CNP Group Practice Provider Program. One application is required for the group, and an additional application is required for each CNP wishing to be a member of the group. Photocopies of the application form can be used for additional practitioners.

Each member of the group practice must have an individual provider number. The rendering provider’s provider number must be present in the Operating field (Box 77) on the UB-04 claim form and in the Rendering Provider ID Number field (Box 24J) on the CMS-1500 claim form.

Group members who have an additional office can bill with either their group practice or individual provider number. CNPs practicing at a group location only must bill through the group provider number.

To apply for an individual or group provider number, practitioners should contact:

Department of Health Care Services  
Provider Enrollment Division  
MS 4704  
P.O. Box 997413  
Sacramento CA 95899-7413  
(916) 323-1945

For additional information, refer to the Provider Guidelines section of the Part 1 manual.
Billing and Reimbursement

CNP providers can bill only for services within their scope of practice and for services that would be covered by Medi-Cal if performed by a physician. All CNP services are reimbursed at 100 percent of the amount paid to physicians for the same service.

CNP services are billed on the CMS-1500 claim form using physician procedure codes and modifiers.

Modifier

CNP providers billing for services with their own provider numbers must not use nurse practitioner modifier SA. This modifier is reserved for physicians, hospital outpatient departments, or organized outpatient clinics that bill CNP services.

When billing for services with their own provider numbers, CNPs may use any modifier (except SA) appropriate to the procedure code billed.
Certified Nurse Midwife
A Certified Nurse Midwife (CNM) is a Non-Physician Medical Practitioner (NMP) who is licensed as a Registered Nurse (RN) and certified as a nurse midwife by the California Board of Registered Nursing. A CNM may be employed by a Medi-Cal provider or be an independent Medi-Cal provider.

Primary Care Defined
Primary care is defined as health professional services provided in a continuing relationship established with an individual or family group. Primary care includes:

- Surveillance of health needs
- Access to comprehensive health care
- Referral to other health professionals
- Health counseling and patient education

Supervision Requirements
The service of CNMs may be billed to Medi-Cal only if the following criteria have been satisfied.

Physician Supervision
Primary care services rendered by a CNM must be performed under the general supervision of a physician. The physician may be engaged in private practice or may be a member of the medical staff of a hospital outpatient department, an outpatient clinic with surgical facilities or a community clinic. The supervising physician must be available to the CNM in person or through electronic means to provide:

- Supervision to the extent required by California professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral for appropriate care by specialist physicians or other licensed health care professionals

Patient Awareness
Medi-Cal providers who employ or use the services of CNMs must ensure that each patient is initially informed that he/she may be treated by an NMP.
Physician/Practitioner Interface

Medi-Cal providers who employ or use the services of CNMs are required to develop a system of collaboration and physician supervision with each CNM. The physician/practitioner interface document establishes the means by which medical treatment services provided by physicians and CNMs are integrated and made consistent with accepted medical practice. This document must be kept on file at the provider’s office, readily available for review by DHCS.

The Medi-Cal program also has specific requirements for the physician/practitioner interface document:

- In the case of RNs, standardized procedures as required by California Code of Regulations (CCR), Title 16, Article 7, Chapter 14, commencing with Section 1470
- All written protocols issued in collaboration between the physician and the CNM
- All written standing orders of the physician

Number Limitation of CNMs Physician May Supervise

There is no limit to the number of CNMs that a single primary care physician may supervise, except as follows:

- For the purpose of furnishing or ordering of drugs or devices by a CNM, no physician will supervise more than four at a time. The CNM furnishes or orders drugs or devices in accordance with standardized procedures or protocols under the supervision of a physician who has current practice or training in obstetrics and gynecology. Such supervision does not require the physical presence of the physician.

A physician’s co-signature or countersignature is not required for care provided by certified nurse midwives. CNMs must practice in collaboration with a physician and surgeon who have current practice or training in obstetrics and gynecology.

DHCS reserves the right to impose utilization controls and sanctions on CNMs as authorized under applicable federal and state statutes and regulations. Nurses determined by DHCS to have abused the Medi-Cal program or furnished drugs or devices outside of the collaborating physician’s field of expertise are subject to the utilization restrictions, which may include, but are not limited to, the requirement of a countersignature by a supervising physician.

A primary physician, an organized outpatient clinic or a hospital outpatient department must not use more CNMs than can be supervised within the limits previously stated.
CNM Enrollment

CNMs must be enrolled with the DHCS Provider Enrollment Division (PED) for Medi-Cal reimbursement. CNMs must enroll with PED via the Provider Application and Validation for Enrollment (PAVE) portal on the DHCS website (www.dhcs.ca.gov).

All CNMs applying to be Medi-Cal providers must submit an uploaded copy of their nursing license issued by the California Board of Registered Nursing and a copy of their certification as a CNM.

Billing and Reimbursement

The DHCS Provider Enrollment Division processes applications and enrolls CNMs so that they are able to obtain reimbursement from the Medi-Cal program, in response to P.L. 96-499, Section 965, Omnibus Reconciliation Act of 1980. Once CNMs are actively enrolled, the services of CNMs can be billed to Medi-Cal by one of two methods:

- CNM services can be billed by, and reimbursed to, the supervising physician, hospital outpatient department or organized outpatient clinic pursuant to California Code of Regulations (CCR), Title 22, Sections 51503.1 and 51503.2.

- CNM services can be billed to the Medi-Cal program directly by a CNM using the provider number issuance process defined in the Provider Guidelines section of the Part 1 manual.

Note: Although CNMs may bill Medi-Cal directly, they must work under a physician’s supervision to be reimbursed (CCR, Title 22, Sections 51240 and 51241).
Assistant at Surgery

CNMs may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician and surgeon. Reimbursement is determined by the following:

- For “assistant at surgery” services performed by a CNM during a cesarean section (designated by modifier AS), reimbursement equals 85 percent of the fee paid to a licensed physician and surgeon serving as “assistant surgeon.”

- For “assistant surgeon” services performed by a licensed physician and surgeon or by a physician assistant (designated by modifier 80), reimbursement equals 20 percent of the surgeon’s fee paid to the licensed physician and surgeon performing the cesarean section.

- Only non-global cesarean section CPT codes 59514 (cesarean delivery only) or 59620 (cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery) are a reimbursable service when submitted with an appropriate assistant surgeon modifier (80).

- The licensed physician and surgeon performing the cesarean section must state on the operative report that the CNM performed the function of an “assistant at surgery.”

- The CNM will not be permitted to be reimbursed directly by both the surgeon performing the cesarean section and by the Department of Health Care Services (DHCS) Medi-Cal program.

- To be reimbursed directly by DHCS Medi-Cal program, the CNM (provider type 005) must be enrolled with the California Medi-Cal Provider Enrollment Division as an independently enrolled non-physician medical practitioner (NMP) and must bill independently using his or her own National Provider Identifier (NPI) number, and cannot be employed by the hospital or medical institution where the surgery is performed.

- The CNM must maintain his or her own professional medical/surgical liability insurance coverage delineating coverage to include liability protection while performing in the capacity of “assistant at surgery.”

- The licensed physician and surgeon performing the cesarean section must provide the CNM with a standard operating procedure delineating the duties, functions, skills and responsibilities that the CNM will perform during the cesarean section.

- The patient undergoing the cesarean section must be a currently enrolled Medi-Cal recipient eligible for services at the time of the surgery.
Covered Services

Only the following HCPCS and CPT codes are reimbursable when performed by a CNM within the scope and limitations of his or her practice. Additionally, services ordered by a CNM, with the exception of prescription drugs, are covered to the same extent as if ordered by a physician.

Surgery (includes contraceptives, obstetrics, gynecology and maternal care services)

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Drugs Administered Other than Oral Method (includes contraceptive implants)

**HCPCS Code**

J7307

Comprehensive Perinatal Services Program (CPSP)

**HCPCS Code**

§ S0197  § Z1032ZL  § Z6200 thru Z6500

Pathology (includes immunology and hematology)

**CPT Codes**

81005  81025  85014  85651  86485 thru 86585  87210

**HCPCS Codes**

C9803  ~S3620

Evaluation and Management

**CPT Codes**

96127  99385  «99454»
「99091」  99395  «99457»
99202 thru 99215  99406  «99458»
99221 thru 99233  99407  99460 thru 99462
99281 thru 99283  99415  99465
99304 thru 99309  99416
99341 thru 99394  «99453»

「HCPCS Codes」

G0442  H0049  H0050

Health and Behavior Assessment/Intervention

**HCPCS Codes**

G8431  G8510  G8431  G8510
T2047  Q9001 thru Q9003

Part 2 – Non-Physician Medical Practitioners (NMP)
### General Medicine

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Part 2 – Non-Physician Medical Practitioners (NMP)
General Medicine (continued)

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Injections/Vaccines

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Injections/Vaccines (continued)

**HCPCS Codes (continued)**

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### Injections/Vaccines (continued)

#### HCPCS Codes (continued)

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#### Non-Injectable Drugs

#### HCPCS Codes

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#### Drugs Administered Other than Oral Method (includes contraceptive implants)

#### HCPCS Codes

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### Health and Behavior Assessment/Intervention

#### CPT Codes

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Multiple Modifier 99

If a multiple modifier is needed to further define CNM services, modifier 99 is entered in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim, in addition to any applicable modifiers, including SB for Certified Nurse Midwife services.

Modifier 99 Billing Example

In this billing example, a certified nurse midwife sees a patient for an initial comprehensive antepartum office visit (HCPCS code Z1032), which occurred within 16 weeks of the patient’s last menstrual period. The provider enters code Z1032-99 in the Procedures, Services or Supplies field (Box 24D). In the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim document:

99 = SB + ZL

Medicare/Medi-Cal-Eligible Recipients

Services provided by an independent CNM are not benefits of the Medicare program. Services to recipients eligible for Medicare must be billed through the physician. Services billed by CNMs as individual providers must be submitted to Medi-Cal directly and not through Medicare as crossover claims.

CMSP Eligible Recipients

Recipients of the County Medical Services Program (CMSP) lose their coverage under CMSP during pregnancy. The recipient must be referred to the county welfare office to establish eligibility under Medi-Cal. All services for the duration of the pregnancy must be billed directly to Medi-Cal.
**Licensed Midwives**

**Licensed Midwives**
Licensed midwives (LMs) are authorized to become Medi-Cal providers and render obstetrical services as independent practitioners.

**Obstetrical Services**
LMs are authorized to perform obstetrical services without supervision of a licensed physician or surgeon and are permitted to bill directly for services rendered, excluding Comprehensive Perinatal Services Program services where LMs can only be employed as contract service providers.

**Limitations**
LMs are restricted from the following:
- Prescribing contraceptive medications and/or prescription drugs
- Inserting intrauterine contraceptive devices
- Inserting subdermal contraceptive implants
- Prescribing contraceptive hormonal patches

These contraceptive options require a prescription written by an appropriately licensed health care practitioner.

**Billing and Reimbursement**
LMs can bill for services only within their scope of practice as non-physician licensed practitioners with established protocols, procedures and treatments authorized pursuant to *California Code of Regulations* (CCR), Title 16, Article 5, Chapter 4, commencing with section 1379.30.
Covered Services

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), DHCS has authorized the use of modifier U9 as the exclusive modifier to identify services rendered by an LM. The following CPT and HCPCS codes may be submitted for reimbursement by an LM when billed with modifier U9.

**Codes Billable by an LM when Billed with Modifier U9**

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**Modifiers**

LMs can bill directly using modifier U9 when performing obstetrical services without the supervision of a licensed physician or surgeon.
Legend
Symbols used in the document above are explained in the following table.

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<tr>
<td>*</td>
<td>High-risk consultation services must be performed by a perinatologist</td>
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<td>±</td>
<td>Nurse Practitioners may only provide services for codes S0197, Z1032ZL and Z6200 thru Z6500 as a CPSP contract service provider.</td>
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<tr>
<td>§</td>
<td>Only CNMs who are enrolled CPSP providers may bill using these codes.</td>
</tr>
<tr>
<td>†</td>
<td>The licensed physician and surgeon performing the cesarean section must list the CNM as “assistant at surgery” on the operative report for CNMs to be reimbursed.</td>
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<td>This service, referred to an approved outside lab, should be billed with modifier 90. Refer to the <em>Pathology: An Overview of Enrollment and Proficiency Testing Requirements</em> section of the appropriate Part 2 provider manual for further information regarding reference laboratories and modifier 90.</td>
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