Non-Physician Medical Practitioners (NMP)

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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). Billing guidance for Licensed Midwives (LMs) are also listed in this section. The following information does not detract from the fact that CNMs, NPs (including family and pediatric specialties) and LMs can enroll as free-standing individual providers and provider groups. PAs, NPs, and CNMs can also enroll as NMPs. For additional help, refer to the *Non-Physician Medical Practitioners* (NMP) *Billing Example* section of this manual.

Note: ‹‹Only a provider with a *Clinical Laboratory Improvement Amendments* (CLIA) certificate and state license or registration appropriate to the level of tests performed may be reimbursed for clinical laboratory tests or examinations. For additional information, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section and the *Pathology: Billing and Modifiers* 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.

Physician Assistants

Physician Assistants (PAs) are Non-Physician Medical Practitioners (NMPs) that are licensed by the Physician Assistant's Board 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(s). A practice agreement must be established. The practice agreement can be a collaboration among one or more physicians and one or more PAs. The practice agreement establishes policies, procedures and meets any other requirements set forth between these practitioners. 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 need not be physically present, but the supervising physician must be available to the PA in person or through electronic means to provide supervision to the extent required by California professional licensing laws and as established in a practice agreement.

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 PA.

Physician/Practitioner Interface Practice Agreement

Medi-Cal providers who employ or use the services of PAs are required to establish a practice agreement and must be competent to perform the medical services in the agreement. 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 practice agreement:

- 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 the practice agreement between the physician and the PA.
- All written standing orders of the physician pursuant to the practice agreement.

Number Limitation of PAs Physician May Supervise

A single physician is limited to supervising four PAs (full-time equivalents) except as otherwise provided by law.

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 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 national number (NPI) must be entered as the rendering physician 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

‹‹The physician or surgeon bills for the services provided pursuant to the practice agreement and within a PA's scope of practice.››

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.

Modifiers for PA Services

HCPCS Modifier	Definition
U7	Medicaid level of care 7, as defined by each state. Used to denote services rendered by PA.
99	Multiple Modifiers

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

HCPCS Modifier	Definition
99	Multiple Modifiers

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 practice after completing a clinical and didactic educational program 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.

Supervision Requirements

‹‹Physician Supervision is required for services rendered pursuant to Business and Professions Code, (BPC) Section 2725.

The requirements regarding physician supervisions for services rendered by NPs that may be billed to Medi-Cal are described below.

Physician Supervision

Services rendered by an NP who functions pursuant to the standardized procedure described in BPC Section 2725(c), 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.

Physician supervision is not required for services rendered pursuant to BPC, Sections 2837.103 and Section 2837.104. Subject to certain limitations, certain classes of NPs, as described in BPC, Sections 2837.103 and 2837.104, may practice, in specified settings where physicians practice, without utilizing standardized procedures, or can work in a setting without a practicing physician if they possess a master's degree in nursing as well as three years of practice in good standing as a nurse practitioner, in addition to a "transition to practice" three-year requirement. Refer to BPC, Sections 2837.103 and 2837.104 and any implementing regulations for instructions about when supervision is not required.››

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 an NP who functions pursuant to a standardized procedure described in BPC Section 2725(c), are required to develop a system of collaboration and physician supervision with each NP. The physician/practitioner interface document establishes how 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.

‹‹The above requirements do not apply to any NP functioning pursuant to BPC, Sections 2837.103 or 2837.104.››

Number Limitation of NPs Physician May Supervise

‹‹There is no limit to the number of NPs that a single physician may supervise, pursuant to BPC, Section 2725 except as follows:››

- For 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.

‹‹The above requirements do not apply to any NP functioning pursuant to BPC, Sections 2837.103 or 2837.104.››

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 who functions pursuant to a standardized procedure described in BPC, Section 2725 (c),›› 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.

‹‹Reimbursement for services rendered by an NP who functions pursuant to BPC, Sections 2837.103 or 2837.104 can be made to the NP.››

Covered Services

‹‹NP Providers can bill only for services within their scope of practice pursuant to California Business and Professions Code (BPC) 2725.››

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

HCPCS Modifier	Definition
SA	Nurse Practitioner rendering service in collaboration with a physician
99	Multiple modifiers

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

HCPCS Modifier	Definition
99	Multiple modifiers

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

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 Specialty

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.

Supervision Requirements

Physician supervision is not required for any CNM practicing pursuant to BPC, Section 2746.5. CNMs render services as independent providers for the scope of services delineated in BPC 2746.5(a). ‹‹Pursuant to Business and Professions Code 2746.5(b), CNMs rendering care that is consistent with the CNM's educational preparation and training but not included in the scope of services outlined in BPC 2746.5(a), function pursuant to mutually agreed-upon policies and protocols signed by a physician and the CNM that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care.››

A physician's co-signature or countersignature is not required for care provided by CNMs.

Patient Awareness

‹‹According to BPC 2746.54, 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 CNM and develop a patient care plan.››

Physician/Practitioner Interface

‹‹Medi-Cal providers who employ or use the services of CNMs who function pursuant to mutually agreed-upon policies and protocols with a physician as described in BPC, Section 2746.5(b), specifically for rendering care not included in the scope of services described in BPC, Section 2746.5(a), are required to develop a physician/practitioner interface document that establishes how 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:

- All written policies and protocols issued in collaboration between the physician and the CNM pursuant to BPC, Section 2746.5.
- ‹‹The mutually agreed-upon policies and protocols signed by a physician and the midwife suffice for requirement (c). If the midwife is only working within scope described in BPC, Section 2746.5(b) the written protocols need only state that the midwife and physician work together collaboratively within their respective scope.

CNMs Ordering Drugs or Devices

Pursuant to BPC 2746.51, CNMs may furnish or order drugs or devices consistent with the care and the CNMs scope of services described in BPC 2746.5(a). There is no physician supervision requirement for CNMs for the purpose of furnishing or ordering of drugs or devices.››

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 inconsistent with state law as described in BPC Section 2746.51 are subject to the utilization restrictions, which may include, but are not limited to, the requirement of a countersignature by a physician.

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*). ‹‹See PAVE for all enrollment requirements.››

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 physician, hospital outpatient department or organized outpatient clinic which employs or utilizes the CMN 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.

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.”
- 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

‹‹CNM providers can bill only for services within their scope of practice as defined by BPC code 2746-2746.8.››

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 licensed by Medical Board of California and perform direct patient care services. LMs are authorized to become Medi-Cal providers and render midwifery services as independent practitioners or serve in a specialty clinic authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical and delivery services.››

Billing and Reimbursement

‹‹LMs can bill for services pursuant to their scope of practice as licensed practitioners with established protocols, procedures and treatments authorized pursuant to BPC 2505-2521.

LM providers must not bill for services that are provided to the same patient on the same day that are duplicative to services that are reimbursed through other Medi-Cal providers.››

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.

Modifiers

LMs can bill directly using modifier U9 when performing obstetrical services without the supervision of a licensed physician or surgeon.

‹‹Enrollment

LMs must be enrolled through the DHCS Provider Enrollment Division (PED) for Medi-Cal reimbursement. The LM and employing provider, if applicable, must enroll with PED via the Provider Application and Validation for Enrollment (PAVE) portal listed on the DHCS Licensed Midwife application information website.››

‹‹Billing Options

The billing method is based on the provision of services and specific billing codes provided by LMs. The billing methods are described below.

Global Billing (GB)

1. A LM who does render total obstetrical care during the recipient's entire pregnancy or who renders at least 13 antepartum visits must bill using the global billing codes.
2. GB does not include Comprehensive Perinatal Service Program services (CPSP). CPSP codes must be billed separately.

Refer to the following provider manual sections: *Pregnancy Global Billing Codes, Pregnancy Global Billing, and Comprehensive Perinatal Service Program (CPSP)*.

Per Visit Billing (PVB)

1. LM who does not render total obstetrical care during the recipient's entire pregnancy or who renders fewer than 13 antepartum visits must bill each visit or procedure separately.

Refer to the following provider manual sections: *Pregnancy Per Visit Billing, Pregnancy Per Visit Billing Codes, Pregnancy Postpartum and Newborn Referral Services, Comprehensive Perinatal Service Program (CPSP)*, and *Alternative Birth Center*.

See the following billing code matrix for all reimbursable individual LM Per Visit billing codes.››

LM Billing Code Matrix

Table of Licensed Midwife Codes

Code Type	Code	Code Description
CPT	31500	Intubation, endotracheal, emergency procedure
CPT	36406	Bl draw less than three years, other vein
CPT	51701	Insert bladder catheter
CPT	51702	Insert temp bladder catheter
CPT	57170	Fitting of diaphragm
CPT	58301	Remove intrauterine device
CPT	59025	Fetal nonstress test
CPT	59300	Episiotomy or vaginal repair
CPT	59400	Obstetrical care
CPT	59409	Vaginal delivery only (with or without episiot)
CPT	59414	Deliver placenta
CPT	59430	Postpartum care only
CPT	59610	Vbac delivery
CPT	59612	Vaginal delivery only after pre. C-section
CPT	76801	Obstetric ultrasound less than 14 weeks single fetus

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
CPT	76815	Obstetric ultrasound limited fetus(s)
CPT	76816	Obstetric ultrasound follow-up per fetus
CPT	81000	Urinalysis nonauto with scope
CPT	81002	Urinalysis, nonauto without scope
CPT	81015	Microscopic exam of urine
CPT	81020	Urinalysis two or three glass set
CPT	81025	Urine pregnancy test
CPT	87210	Wet mount
CPT	90384	Rho(d) immune globulin human full-dose
CPT	90385	Rho(d) immune globulin human mini-dose
CPT	90386	Rho(d) immune globulin human intravenous
CPT	94760	Measure blood oxygen level
CPT	96127	Brief emotional/behavioral assessment
CPT	96156	Health behavior assessment or reassessment
CPT	96158	Health behavior intervention, individual initial 30 minutes

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
CPT	96159	Health behavior intervention, individual each additional 15 minutes
CPT	96164	Health behavior intervention, group, initial 30 minutes
CPT	96165	Health behavior intervention, group additional 15 minutes
CPT	96360	Hydration IV initial
CPT	96361	Hydrate IV add-on
CPT	96365	Therapy, prophylaxis or diagnosis IV initial
CPT	96366	Therapy, prophylaxis or diagnosis IV add-on
CPT	96367	Therapy, prophylaxis or diagnosis IV additional sequential infusion
CPT	96368	Therapy, prophylaxis or diagnosis concurrent infusion
CPT	96372	Therapeutic, prophylactic or diagnosis injection subcutaneous or intramuscular
CPT	96373	Therapeutic, prophylactic or diagnosis injection intra-arterial
CPT	96374	Therapeutic, prophylactic or diagnosis injection IV push
CPT	96375	Tx/pro/dx inj new drug addon
‹‹CPT	97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)››
‹‹CPT	97022	Application of a modality to 1 or more areas; whirlpool››
CPT	99000	Specimen handling office-lab
CPT	99050	Services in office outside of reg hours
CPT	99051	Services in office reg schedule evening/wknd/holiday
CPT	99053	Services at 24-hour facility
CPT	99056	Out of office call
CPT	99058	Emergency services during office hours without appointment
CPT	99060	Emergency services outside office during office hours
CPT	99070	Special supplies physician or qualified health care professional

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
CPT	99071	Provides educational material at own expense to educate patient
CPT	99072	Uses items, materials, or clinical staff in excess
CPT	99075	Review medical records and renders medical opinion
CPT	99078	Group instruction as patient education
CPT	99080	Completes form or reports for patient status
CPT	99082	Travel time per medical per hour
CPT	99091	Collect/review data from patient
CPT	99202	Office o/p new sf 15-29 min
CPT	99203	Office o/p new low 30-44 min
‹‹CPT	99204	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more››
CPT	99211	Office o/p est minimal prob
CPT	99212	Office o/p est sf 10-19 min
CPT	99213	Office o/p est low 20-29 min
‹‹CPT	99214	Established patient office or other outpatient visit with low level of decision making, if using time 30 minutes or more››
CPT	99341	Home/res vst new sf mdm 15
CPT	99342	Home visit new patient (low mdm)
CPT	99347	Home visit est patient (sf)
CPT	99348	Home/res vst est low mdm 30
CPT	99358	Prolong service without contact
CPT	99359	Prolong service with contact
CPT	99366	Team conf with patient by hc pro
CPT	99368	Team conf without patient by hc pro
CPT	99381	Initial/periodic comprehensive preventive medicine age younger than 1 year

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
CPT	99385	Initial/periodic comprehensive preventive medicine 18-39 years
CPT	99386	Initial/periodic comprehensive preventive medicine 40-64 years
CPT	99391	Initial/periodic comprehensive preventive medicine age young than 1 year
CPT	99395	Initial/periodic comprehensive preventive medicine 18-39 years
CPT	99396	Initial/periodic comprehensive preventive medicine 40-64 years
CPT	99406	Behav chng smoking 3 10 min
CPT	99407	Behav chng smoking greater than 10 min
CPT	99417	Prolonged outpatient services
CPT	99429	Unlisted preventive med.
CPT	99451	Ntrprof ph1/ntrnet/ehr 5/>
CPT	99452	Ntrprof ph1/ntrnet/ehr 30 min
CPT	99453	Rem mntr physiol param setup

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
CPT	99454	Rem mntr physiol param dev
CPT	99457	Rem physiol mntr 1st 20 min
CPT	99458	Rem physiol mntr ea addl 20
CPT	99460	Init nb em per day hosp
CPT	99461	Init nb em per day non-fac
CPT	99462	Sbsq nb em per day hosp
CPT	99463	Same day nb discharge
CPT	99464	Attendance at delivery
CPT	99465	Nb resuscitation
CPT	99466	Ped crit care transport
CPT	99467	Ped crit care transport addl
CPT	99468	Neonate crit care initial
CPT	99500	Home visit prenatal monitoring and assess
CPT	99501	Home visit postnatal
CPT	99502	Home visit nb care
CPT	99506	Home visit for intramuscular injections
CPT	99600	Unlisted home visit svc/px

‹‹Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
HCPCS	A4261	Cervical cap contraceptive
HCPCS	A4265	Paraffin per pound
HCPCS	A4266	Diaphragm for contraceptive
HCPCS	A4267	Male condom
HCPCS	A4268	Female condom
HCPCS	A4269	Spermicide
HCPCS	A4627	Spacer; bag, or reservoir with or w/out mask
HCPCS	A4628	Oropharyngeal suction catheter
HCPCS	A4649	Surgical supply; miscellaneous
HCPCS	C9803	Specimen collect outpt hosp COVID-19
HCPCS	G0310	Immunize counsel five to 15 min
HCPCS	G0311	Immunize counsel 16-30 mins
HCPCS	G0312	Immunize couns less than 21yr 5-15 minutes
HCPCS	G0313	Immunize couns less than 21yr 6-30 minutes
HCPCS	G0314	Counsel immune less than 21 16-30 minutes
HCPCS	G0315	Counsel immune less than 21 5-15 minutes
HCPCS	G0442	Annual alcohol screen 15 minutes
HCPCS	G2010	Remote image submit by pt
HCPCS	G2012	Brief check in by md/qhp
HCPCS	G2023	Speciman collect acute respiratory syndrome COVID-19
HCPCS	G2024	Speciman collect acute respiratory syndrome COVID-19
HCPCS	G8431	Pos clin depres scrn f/u doc
HCPCS	G8510	Pt ingelig neg scrn depres››

‹‹Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
HCPCS	G9919	Aces screening (high risk)
HCPCS	G9920	Aces screening (low risk)
HCPCS	H0033	Oral med adm direct observe
HCPCS	H0049	Alcohol/drug screening
HCPCS	H0050	Alcohol/drug service 15 min
HCPCS	J0131	Acetaminophen injection
HCPCS	J0290	Ampicillin 500 mg injection
HCPCS	J0456	Azithromycin
HCPCS	J0561	Penicillin g benzathine injection
HCPCS	J0690	Cefazolin sodium injection
HCPCS	J0696	Injection, ceftriaxone sodium, per
HCPCS	J0736	Clindamycin
HCPCS	J1200	Injection, diphenhydramine hcl, up
HCPCS	J1750	Inj iron dextran
HCPCS	J1756	Iron sucrose injection
HCPCS	J1885	Injection, ketorolac tromethamine, 15mg
HCPCS	J2001	Lidocaine injection
HCPCS	J2210	Injection, methylergonovine maleat
HCPCS	J2405	Odansetron hydrochloride, per 1mg
HCPCS	J2510	Injection, penicillin g procaine
HCPCS	J2540	Injection, penicillin g potassium››

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
HCPCS	J2590	Injection, oxytocin, up to 10 unit
HCPCS	J2788	Rho d immune globulin 50 mcg
HCPCS	J2790	Rho d immune globulin injection
HCPCS	J2791	Rhophylac injection
HCPCS	J2792	Rho(d) immune globulin h, sd
HCPCS	J3430	Injection, vitamin k, phytonadione
HCPCS	J3490	Unclassified drugs
HCPCS	J3590	Unclassified biologics
HCPCS	J7030	Infusion, normal saline solution
HCPCS	J7040	Infusion, normal saline solution
HCPCS	J7042	Five percent dextrose/normal saline (500 ml)
HCPCS	J7050	Infusion, normal saline solution
HCPCS	J7060	Five percent dextrose/water (500 ml equals 1 unit)
HCPCS	J7070	Infusion, d5w, 1000 cc
HCPCS	J7100	Infusion, dextran 40
HCPCS	J7110	Infusion dextran 75
HCPCS	J7120	Ringers lactate infusion, up to 1000
HCPCS	M0201	COVID-19 vaccine home admin
HCPCS	M0222	Intravenous injection post admin monitor
HCPCS	M0223	Intravenous injection post admin monitor in home

Table of Licensed Midwife Codes (continued)

Code Type	Code	Code Description
HCPCS	Q0111	Wet mounts/ w preparations
HCPCS	Q0112	All potassium hydroxide (koh) preparation
HCPCS	S0191	Misoprostol, oral, 200 mcg
HCPCS	S3620	Newborn metabolic screening
HCPCS	S5190	Wellness assessment performed by non-physcian
HCPCS	S8265	Haberman feeder
HCPCS	T1013	Sign language or oral interpretive services/15 minutes
HCPCS	T1014	Telehealth
HCPCS	Z1032	Initial antepartum office visit
HCPCS	Z1034	Antepartum follow-up office visit
HCPCS	Z1038	Postpartum follow-up office visit
‹‹HCPCS	Z7500	Use of hospital, exam or treatment room››
‹‹HCPCS	Z7516	Us of facility birthing center services››

CPSP

HCPCS Codes

S0197	Z6302	Z6406
Z6200	Z6304	Z6408
Z6202	Z6306	Z6410
Z6204	Z6308	Z6412
Z6206	Z6400	Z6414
Z6208	Z6402	Z6500
Z6300	Z6404	

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	High-risk consultation services must be performed by a perinatologist
±	Nurse Practitioners may only provide services for codes S0197, Z1032ZL and Z6200 thru Z6500 as a CPSP contract service provider.
§	Only CNMs who are enrolled CPSP providers may bill using these codes.
†	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.
~	This service, referred to an approved outside lab, should be billed with modifier 90. Refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section of the appropriate Part 2 provider manual for further information regarding reference laboratories and modifier 90.