Reimbursement Policy

Scope of License, Scope of Practice, and Provider Qualifications

REIMBURSEMENT POLICY NUMBER: 8

Effective Date: 6/1/2025

Last Review Date: 5/2025

Next Annual Review: 5/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ All health care services billed on CMS 1500 forms

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

NOTES:

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

- For the purposes of this policy, the terms “scope of practice” and “scope of license” are used interchangeably.
- This policy is not intended to exclude any provider type. Examples are provided for illustrative purposes only. This policy will apply to any individual who may render medical, behavioral, dental, or vision health services to any Plan member.

I. The Plan **may allow reimbursement** for the performance of medically necessary procedures or services that are within a provider’s scope of license (or scope of practice) under state law and in accordance with CMS guidelines.

II. The provider must satisfy **all** of the following requirements:

A. Meet the state and federal requirements for the performance of such service or procedure; **and**
B. Be licensed to perform the service or procedure by the state in which the provider practices; **and**
C. Perform the service or procedure they are legally authorized to provide under their professional licensure; **and**
D. Be qualified, with the proper education and training for the service being reported. (To support “proper experience and training,” examples include, but may not be limited to, board certification requirements, testing for licensing examinations includes the service in question, hours of experience providing the service in a supervised setting during the certification process, etc.).

III. The Company shall have sole authority in determining whether an individual who performs a service is qualified. The Company will consider generally accepted practices but retains authority for any final determination.

IV. All services must be covered benefits for the individual member, medically necessary, and correctly coded.

V. All diagnostic testing services ordered must be part of the established treatment plan of the ordering professional, for the medical condition for which the testing is directed and must be supported by documentation in the medical record.

VI. Procedures and services performed outside of the provider’s scope of license are **not reimbursable**.

POLICY GUIDELINES

DEFINITIONS

Scope of Practice.

According to the American Medical Association (AMA), “Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly

determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity."[1]

According to Oregon.gov, many considerations go into scope of practice decisions. It states:

> "While the ultimate decision on scope of practice issues generally rests with the Legislature, the Board assists lawmakers by providing complete and accurate information upon which to base decisions. The following factors are considered when the Board reviews scope of practice questions:
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> - Public safety must be the primary focus;
> - The patient should receive the same level of care and informed consent regardless of who provides the care;
> - Fully qualified providers must perform procedures, whether those providers are physicians or other health care professionals. With extensive years of medical training, physicians have broad authority and considerable latitude in the scope of their medical practice. Health care providers with less formal education need a clearly defined scope of practice in keeping with Oregon statutes.
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> When considering scope of practice changes for professions or individuals under its own jurisdiction, the Board considers the following:
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> - **Education**: Has the provider received education from an approved institution with national standards and what is the core education in terms of residency, post-graduate education and continuing education courses?
> - **Experience**: What experience has the practitioner had recently relative to the proposed expansion in scope of practice?
> - **Level of Supervision:** When health care professionals work under supervision, the Board expects the supervisor to be identified in advance and to be skilled in the procedure he/she is supervising. The supervisor must also assume responsibility for delegation of duties.
> - **Back-up Assistance Available:** Before undertaking a scope of practice change, a functional back-up system must be identified in advance, with the availability of review similar to hospital peer review.
> - **Demonstration of Skill Level:** In assessing ability, the Board looks for proficiency demonstrated under supervision, documented by an unbiased third party. There needs to be verified outcomes following an appropriate number of procedures over a given period of time.
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> Prior to the addition of a diagnostic or therapeutic technique to a health practitioner's scope of practice under any jurisdiction, the Board believes that the following questions should be answered in addition to the above outlined standards:
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> - What is the current standard of practice and is the skill being added appropriate to the professional background?

- What background is sufficient to prepare the professional to perform a given procedure safely?
- Does the individual have adequate experience to understand appropriate indications and handling of complications?"[2]

PURPOSE

The purpose of this policy is to describe situations where a healthcare professional's qualifications, experience, training, and/or expertise may be insufficient to render a specific service or procedure. The implementation of this policy is intended to target the following objectives for our members:

- Quality of care rendered to our members
- Patient safety
- Accurate and appropriate procedural coding

This policy is intended to consider unique training of medical, behavioral, dental and vision care providers, to ensure necessary education and training requirements are met for a given service, to reduce jeopardization to a member's safety.

BACKGROUND

Health Care Services Ordered and Furnished by Qualified Personnel

In order to be considered medically reasonable and necessary, Medicare expects services to be rendered "ordered and furnished by qualified personnel."[3]

Every health care professional has an important role to play in the health care system. Nonphysician health care professionals can provide safe and essential health care when part of a physician led care team. However, some services and procedures require additional education and experience of a fully trained physician.

When such procedures or services are performed by nonphysicians – and even physicians who have limited training or experience for a given procedure or service – the health and safety of members can be threatened when services are performed beyond the boundaries of what the rendering provider has been educated and clinically trained to perform.[1] In addition, the quality of the care the member receives may be diminished if rendered by an inexperienced or untrained provider when compared to receiving the same service from a provider with more appropriate qualifications and experience. By expecting only qualified providers to render services in which they are trained and experienced to perform, avoidable complications in the future can be prevented. This safety of members extends to not only an individual's physical safety, but also their mental health well-being as well.

According to guidelines set by the Centers for Medicare and Medicaid Services (CMS), "…For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law…"[4]

Appropriately Reporting Services

Some CPT codes may be intended for certain provider types (physician or nonphysician) or specialties. Sometimes this intended use of a procedure or service is found within the description of the code.

> **Example**: CPT 98960 describes education and training for patient self-management by a qualified, *nonphysician* health care professional.

Other times, the AMA provides parenthetical information or coding guidance within the CPT book with instruction.

> **Example**: CPT 96041 which says, "These services are provided by trained *genetic counselors* and may include obtaining a structured family genetic history, pedigree construction, analysis for genetic risk assessment, and counseling of the patient and family."

Not all CPT or HCPCS codes may be limited to certain specialties or provider types. However, in all situations, in order to report a CPT or HCPCS code, all elements required for the reporting of that code must be met. With regard to CPT code selection, the American Medical Association (AMA) Current Procedural Terminology (CPT®) states, "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided."[5]

If a health care professional submits a claim for services for which they may not be qualified to perform or for services which may not fall under the scope of that professional's license, the claim may be subject to audit. This will be to confirm appropriate code selection and to confirm all elements that are required to report the CPT or HPCS code in question were satisfied.

> **Example #1:** A massage therapist or podiatrist should not submit claims for psychotherapy because neither a massage therapist nor a podiatrist would be considered a qualified health care professional for psychotherapy services, nor would a massage therapist or podiatrist be expected to have the clinical expertise, training, or experience to be qualified to provide psychotherapy services because their training, education and testing would not have included psychotherapy in the curriculum. Psychiatry and psychology are specialized fields for the diagnosis and treatment of various mental health disorders and/or diseases. Therefore, claims for psychotherapy submitted by a massage therapist or podiatrist may be subject to audit to confirm the services were rendered within the scope of their respective licenses **and** that all elements required to report psychotherapy procedures are documented within the medical record as being rendered.

> **Example #2:** A claim for breast augmentation submitted by an oral surgeon may be subject to audit because an oral surgeon would not be considered a qualified health care professional for breast augmentation procedures, nor would an oral surgeon be expected to have the clinical expertise, training, or experience to be qualified to provide breast augmentation procedures because their training, education and testing would not have included plastic surgery of both the male and female breast, including its tissues and surrounding structures in the curriculum. Claims for breast reconstruction procedures submitted by an oral surgeon may be subject to audit to confirm the services were rendered within the scope of their respective licenses **and** that all elements required to report the breast reconstructive surgery are documented in the medical record.

IMPORTANT NOTE: While the Company will consider generally accepted practices, it retains sole authority for the final determination regarding whether a person who performs a service is qualified, with the proper course training and experience in a supervised setting.

Ordering Diagnostic Tests

Ordering health care professionals, whether physicians or nonphysicians, are expected to use the requested test results to manage and direct the patient care for a specific medical condition for that patient.

Examples:

- A psychiatrist or a massage therapist is not likely to use a cardiac CT scan or a battery of blood tests to manage a patient's cardiac condition.
- A cardiologist is not likely to use genetic test results to manage a patient's breast cancer.

Therefore, a diagnostic test may be denied as **not medically necessary** if the ordering health care professional is not ***directly*** managing the member's care and treatment plan for the medical condition for which the diagnostic test is directed.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 4/8/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses scope of practice and licensing:

- CMS. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, 190.6 - Payment Methodology for Physician/Practitioner at the Distant Site, 2. Payment Amount (professional fee)
- CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services
- CMS. Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.6.2.2 - Reasonable and Necessary Criteria
- 42 CFR §410.32(a)
- CMS. Medicare Benefit Policy Manual, Ch. 15 – Covered Medical and Other Health Services, §80.1 -Clinical Laboratory Services

According to Chapter 12 of the Medicare Claims Processing Manual, "…For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law…" In addition, according to Chapter 3 of the Medicare Program Integrity manual, to be considered medically reasonable and necessary, Medicare expects services to be rendered "ordered and furnished by qualified personnel."

Several other CMS references address "scope of practice" in regard to specific services, including therapies, non-physician services, diagnostic tests, etc. For example, Chapter 15 of the Medicare Benefit Policy Manual includes the following citations:

Diagnostic Tests

"Section 410.32(b) of the Code of Federal Regulations (CFR) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician (§1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare.

However, effective January 1, 2021, the basic rule at 42 CFR 410.32(b)(1) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervision by a physician as defined in §1861(r) of the Act or, to the extent that they are authorized to do so under their scope of practice and applicable State law, by a nurse practitioner, clinical nurse specialist, certified nurse-midwife, certified registered nurse anesthetist or physician assistant. Services furnished without the required level of supervision are not reasonable and necessary."[7]

Psychological and Neuropsychological Tests

"Who May Bill for Diagnostic Psychological and Neuropsychological Tests

- CPs - see qualifications under chapter 15, section 160 of the Benefit Policy Manual, Pub. 100-02.
- NPs -to the extent authorized under State scope of practice. See qualifications under chapter 15, section 200 of the Benefit Policy Manual, Pub. 100-02.
- CNSs -to the extent authorized under State scope of practice. See qualifications under chapter 15, section 210 of the Benefit Policy Manual, Pub. 100-02.
- PAs - to the extent authorized under State scope of practice. See qualifications under chapter 15, section 190 of the Benefit Policy Manual, Pub. 100-02.
- Independently Practicing Psychologists (IPPs)
- PTs, OTs and SLPs - see qualifications under chapter 15, sections 220-230.6 of the Benefit Policy Manual, Pub. 100-02."[7]

Audiological Treatments

"Audiological treatment provided under the benefits for physical therapy and speech-language pathology services may also be personally provided and billed by physicians and NPPs when the services are within their scope of practice and consistent with State and local laws."[7]

42 CFR §410.32(a) and the Medicare Benefit Policy Manual, Chapter 15, §80.1 address requirements for diagnostic testing to be eligible for coverage as medically reasonable and necessary services under Medicare, including being ordered and used promptly by the health care provider who is treating the individual for a condition, and who will use the test results to make diagnosis or treatment decisions for that condition.

CROSS REFERENCES

Incident To Services, RP5

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. American Medical Association (AMA). What is scope of practice?. https://www.ama-assn.org/practice-management/scope-practice/what-scope-practice#:~:text=Scope%20of%20practice%20refers%20to,by%20the%20appropriate%20licensing%20entity. Accessed 4/8/2025.
2. Oregon.gov. website for Scope of Practice. https://www.oregon.gov/omb/board/philosophy/pages/scope-of-practice.aspx. Accessed 4/8/2025.
3. Centers for Medicare & Medicaid Services (CMS). Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.6.2.2 - Reasonable and Necessary Criteria. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf. Accessed 4/8/2025.
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5. AMA. Current Procedural Terminology (CPT) 2024 Professional Edition.
6. National Conference of State Legislatures and ScopeofPracticePolicy.org. https://scopeofpracticepolicy.org/. Accessed 4/8/2025.
7. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/8/2025.
8. 42 CFR §410.32(a); Available at: https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-32.pdf. Accessed 4/8/2025.
9. CMS. Medicare Benefit Policy Manual, Ch. 15 – Covered Medical and Other Health Services, §80.1 -Clinical Laboratory Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf. Accessed 4/8/2025.

POLICY REVISION HISTORY

Date	Revision Summary
8/2024	New Reimbursement Policy
1/2025	Q1 2025 code update
6/2025	Annual review, no changes