the ruling indicates, the treating physician's certification or recertification of the need for care is to be given great weight in determining SNF coverage, but coverage decisions are not made solely based on this certification: ''* * *if the attending physician's certification of the medical need for services is consistent with other records submitted in support of the claim for payment, the claim is paid. However, if the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence'' (HCFAR 93–1–8).

Thus, although an attending physician's certification or recertification that care is needed is to be given great weight in determining SNF coverage, we do not consider a certification or recertification irrefutable in the face of medical evidence to the contrary. We do not believe that a certification or recertification should be considered more binding when completed by a nurse practitioner or clinical nurse specialist than it would have been if completed by the attending physician. Therefore, it is possible for a nurse practitioner or clinical nurse specialist's certification of the need for care to be superseded by medical evidence to the contrary, which can include the opinion of the attending physician. We do not anticipate that such a certification or recertification would be completed in direct contradiction to the attending physician's opinion. For example, if the attending physician disagrees with a nurse practitioner's or clinical nurse specialist's certification of the need for care, the medical review entity can deny coverage, provided that the attending physician's opinion is consistent with the medical evidence in the file.

B. The Definition of ''Collaboration''

In the proposed rule of June 28, 1991, we defined ''collaboration'' as a process whereby a nurse practitioner or clinical nurse specialist works with a doctor of medicine or osteopathy to deliver health care services. The services are delivered within the scope of the practitioner's professional expertise with medical direction and appropriate supervision as provided for in guidelines jointly developed by the practitioner and the physician, or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

Comment: One commenter maintained that HCFA's proposed definition of ''collaboration,'' which provides that appropriate supervision should be provided, implies that a physician should be physically present. The commenter believes this implication is overreaching and does not reflect the professional practice of these practitioners. The commenter contends that physicians are not physically present in the facility at the same time the services are performed.

Response: We do not believe that our proposed definition is overreaching. The requirement that collaboration entail medical direction and supervision does not imply that the physician be physically present in the facility or even that the physician be consulted on each patient. Our definition is meant to apply to the overall relationship between the physician and the nurse practitioner or clinical nurse specialist. Thus, we envision that collaboration would involve some systematic formal planning, assessment, and a practice arrangement that reflects and demonstrates evidence of consultation, recognition of statutory limits, clinical authority, and accountability for patient care, according to some mutual agreement that allows each professional to function independently.

C. The Limitation on Authorization To Sign Certification and Recertification Statements

In the June 28, 1991, proposed rule, we proposed to revise § 424.11(e) to specify that nurse practitioners and clinical nurse specialists be authorized to sign certifications and recertifications for extended care services. We defined these entities as individuals, licensed by the State, who meet the requirements in § 424.20(e).

Comment: One commenter suggested that regulations should provide that the physician assistant, as well as the nurse practitioner and clinical nurse specialist, be allowed to certify and recertify residents for Medicare benefits.

Response: Under current law, physician assistants are not allowed to perform these certifications and recertifications. Section 6028 of OBRA '89 extended the signature authorization for certification and recertification to nurse practitioners and clinical nurse specialists only.

Comment: One commenter indicated that the criteria in the proposed rule that require State licensure for the nurse practitioner and clinical nurse specialist to meet the signature authorization requirements place restraints on many of the nurse practitioners and clinical nurse specialists who are not formally recognized through their State practice acts (that is, formal licensure requirements), but who are not prevented from practicing in those same States. The commenter believes that the lack of a formal licensure program should not prevent this provision from being implemented in a State.

Response: We agree that the proposed qualifications requiring State licensure are unduly restrictive on those nurse practitioners and clinical nurse specialists who are in States that currently authorize them to practice under State law, even though no formal licensure exits. Therefore, we are revising proposed § 424.11(e) to eliminate the requirement for State licensure. Instead, we are setting forth the necessary qualifications that nurse practitioners and clinical nurse specialists must meet for purposes of this provision. As detailed below, these qualification requirements will ensure that the signature authority is extended to nurse practitioners and clinical nurse specialists who are currently authorized under State law to perform such services, even if no formal licensure exists.

Nurse practitioners and clinical nurse specialists are primary health care providers. As a primary health care provider, the nurse practitioner and/or clinical nurse specialist manages care under a framework that includes assessment of health status, diagnosis, development of a treatment plan, implementation of that plan, follow up, and patient education. The autonomous nature of advanced practice nursing requires accountability for outcomes in health care.

In the early years, many of the nurse practitioner and clinical nurse specialist programs were hospital based certificate programs that provided basic education and clinical requirements that were very similar to the requirements that Medicare established in regulations for rural health clinics in § 491.2. In the late 1970's, post-basic advanced practice programs began to evolve in response to societal and health care needs and are rapidly being phased out in favor of master's programs. Most of the educational preparation now required is defined by guidelines established by the profession to assure appropriate knowledge and clinical competency necessary for the delivery of primary health care.

A formal, graduate educational program provides the nurse practitioner and clinical nurse specialist the theoretical knowledge and clinical skills appropriate for their scope of practice that includes clinical, technical and ethical learning experiences for delivery of care and role development in advanced nursing practice. Formal graduate education also enables nurse