The Essential

Guide to PA Reimbursement

2018

AAPA

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INTRODUCTION

Although not every PA needs to be an expert in PA reimbursement policy, it is essential that all PAs have a working knowledge of the payment and coverage policies for the services they provide. CPT codes, QPP, RVUs, value-based reimbursement, bundled payments, EOBs, "incident-to," E/M documentation, and the global surgical period are acronyms and terms that may sound like incoherent jargon unrelated to the medical and surgical services PAs deliver on a daily basis. However, learning this "language" is key to understanding the financial, legal, and regulatory issues regarding coverage by insurance companies and third-party payers for PA-provided services. It goes to the heart of the ability of PAs to meet the appropriate practice guidelines and demonstrate their value to employers and the healthcare system.

PAs are not alone in dealing with misinterpretations and misunderstandings of coverage policies. Physicians and other healthcare professionals throughout the country acknowledge that, at one time or another, they experience some type of problem with reimbursement for their services. But, speaking the language and understanding the issues will help you be better prepared when the inevitable happens.

This book is designed to help PAs, physicians, employers, and billing and coding professionals understand the issues, concepts, and policies regarding payment for PA-provided services. The information provides an overview of PA coverage and payment policy. It also provides insight into the courses of action that can be taken to maximize legitimate reimbursement, help resolve problems, and maintain a positive reimbursement environment. And you can find the terms and definitions of all those acronyms in the glossary at the back of this book.

It is important to note that rules surrounding coverage policies can change. It is up to those who deliver and bill for medical and surgical services to stay up to date if changes occur. Also, policies can differ depending on the state or region in which you practice. Many policies are national, but local rules or state laws often affect rules surrounding the ability of PAs to deliver and bill for services.

MEDICARE

Medicare Overview

The Medicare program is a government-administered social insurance program designed to provide hospital and medical insurance for the elderly and other eligible individuals. In 1965, Congress amended the Social Security Act and established a program called Health Insurance for the Aged, more commonly known as Medicare (Public Law 89-97). The Medicare program officially began on July 1, 1966. Medicare covers eligible individuals aged 65 and older, but also offers coverage for individuals with certain disabilities and those suffering from end-stage renal disease.

Medicare now provides insurance coverage to more than 55 million people. It is administered by the Centers for Medicare and Medicaid Services (CMS). Among other things, CMS is responsible for:

- Interpreting and implementing laws affecting Medicare as passed by Congress.
- Promulgating rules and regulations for the program.
- Contracting with commercial insurance companies throughout the country (also known as Medicare Administrative Contractors or MACs) to process Medicare claims.

The Medicare program is divided into four major parts: A, B, C, and D. Medicare Part A (also known as hospital insurance) covers inpatient hospitalization and nursing facility care, home healthcare, and hospice care.

Medicare Part B (also known as medical insurance) covers professional services provided by physicians, PAs, and certain other authorized healthcare professionals in medical offices, clinics, hospitals, and nursing facilities. Medicare Part B also pays for durable medical equipment. The policies explored in this section primarily pertain to Medicare Parts A and B.

Medicare Part C, commonly called "Medicare Advantage," is an option through which beneficiaries can elect to receive their Medicare coverage from commercial health companies and plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) or other managed care entities. Medicare Advantage plans often have lower copayments and deductibles than traditional fee-for-service Medicare and often offer enhanced benefits packages not available in traditional fee-for-service Medicare. These benefits include additional wellness, dental, and vision services. Medicare pays a fixed, per-person, monthly amount to plans to provide healthcare services to beneficiaries. Medicare Advantage covers approximately 1/3 of Medicare beneficiaries. The coverage policy specifics of individual Medicare Advantage plans may differ from Parts A and B (Medicare fee-for-service) as those plans are operated by commercial payers.

Medicare Part D is a prescription drug plan for seniors. Studies have shown that enrollees enjoy high patient satisfaction with Medicare Part D. However, the program at times has also drawn criticism because of the complicated nature of the various plans and the so-called "donut hole" gap in coverage. The donut hole is the range between Part D's coverage limit and when beneficiaries qualify for catastrophic care coverage. The Affordable Care Act, passed in March 2010, is expected to completely close this gap by 2020.

Medicare and PAs

The history of PA coverage policy under the Medicare program has been one of steady, incremental gains. Medical services provided by PAs were not originally covered by Medicare. This was a result of

the fact that the first PA program (Duke University) began the same year that Medicare legislation was passed.

In the early years of the Medicare program, the only method for coverage of medical services provided by PAs was under Section 1861(s) (2)(A) of the Social Security Act. This section of the law authorizes payment to be made for services that are "furnished as 'incident-to' a physician's professional services, of kinds which are commonly furnished in physicians' offices, and are commonly either rendered without charge or included in the physicians' bills." This typically included services such as giving injections and taking a patient's temperature or blood pressure.

At that time, Medicare coverage for medical services provided by PAs was prohibited for the types of services PAs were educated and trained to perform. Medical services provided by PAs were specifically excluded from coverage (even if the physician was physically present in the office) if the services were typically and characteristically performed by the physician, such as placing a cast, minor surgery, and reading X-rays. An excerpt from an old Medicare Part B Carriers Manual stated:

"There is no provision under Part B which authorizes coverage of the services of physician assistants … and… the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered … even though all the other 'incident-to' requirements are met."

In the 1970s, the attitudes of legislators and policymakers began to change. Both the established medical community and governmental agencies acquired a better understanding of the PA profession, largely in response to a concerted effort by the American Academy of PAs (AAPA).

The Social Security Act amendments of 1972 (Public Law 92-603) provided coverage for the services of a limited number of PAs as part of a pilot program. The conclusion reached as a result of that "experiment" was that medical practices with PAs provided "more visits per thousand dollars of practice cost, at a higher quality of care, and with less charge to the patient … than do traditional practices."

The first statutory success for PAs within the Medicare program was the Rural Health Clinic Services Act (Public Law 95-210) passed by Congress in 1977. This act intended to increase the number of healthcare providers in rural and medically underserved areas, and it provided Medicare coverage for medical services provided by PAs when delivered to Medicare and Medicaid patients in federally certified rural health clinics.

Five years later, the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) covered medical services provided by PAs in HMOs and Competitive Medical Plans, a type of early managed care plan.

Between 1987 and 1997, Medicare covered PAs in nursing facilities and hospitals and for first assisting at surgery at 85%, 75%, and 65% of the Physician Fee Schedule, respectively.

The Balanced Budget Act of 1997 (BBA 1997) expanded Medicare coverage for medical services provided by PAs. Congress, recognizing the increasingly important role of PAs in providing healthcare services to Medicare beneficiaries, extended coverage in outpatient settings, eliminated a number of restrictive practice requirements, increased the rate of reimbursement for services delivered in hospitals and for first assisting at surgery, and made independent contractor employment relations available to PAs. (Medicare's memo regarding the BBA 1997 is located in Appendix A.)

Coverage and Reimbursement

Medicare now covers services provided by PAs in all practice settings at a uniform rate of 85% of the Physician Fee Schedule (See Appendix A; for the current Medicare language regarding PA coverage policy that appears in section 2156 of the Medicare Carriers Manual see Appendix B). Medicare defers to state law requirements for PA collaboration/supervision. Generally, PAs are able to deliver the same range of medical and surgical services to Medicare beneficiaries that physicians provide, as authorized by state law.

When services provided by PAs are billed to Medicare, the claim submitted to Medicare should reflect the full participating physician charge. Do not reduce the bill to 85% of the full charge before submission to Medicare. Use of the PA's National Provider Identifier (NPI) number will alert the carrier to implement the 15% discount. (See the section on "incident-to" billing to see when certain services provided by the PA may be billed under the name of the physician with reimbursement at 100% when a physician is on site and other "incident-to" criteria are met.)

For billing purposes, medical and surgical services provided by physicians and PAs are described using the same Current Procedural Terminology (CPT) codes. Coding for first assisting at surgery, however, differs in that PAs use the -AS modifier for a Medicare surgical first assist, whereas physicians use the -80 modifier. Requirements regarding first assisting differ in a teaching hospital (see the Teaching Hospitals section).

Over the years, specific questions have been raised as to the ability of PAs to bill for certain services and procedures, including high-level evaluation and management (E/M) codes. National Medicare policy is clear that, if allowed by state law, PAs are covered for performing the following (references may be found in the respective appendices):

- High-level evaluation and management services (including levels 4 and 5) (Appendix C)
- Initial hospital histories and physicals (H&Ps) (Appendix C)
- Mental health services (Appendix C)
- Fracture care (Appendix C)*
- Flexible sigmoidoscopies (see 42 CFR 410.37(d) in Appendix D)
- Personally performing all diagnostic tests (see 42 CFR 410.32(b)(3) in Appendix E)
- Telemedicine services (Appendix F)
- Ordering outpatient physical therapy/signing plan of care (Appendix G)
- Signing the certificate of medical necessity for durable medical equipment (DME) (Appendix H)

*National Government Services (NGS), the Part B Medicare Administrative Contractor (MAC) for Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, and Wisconsin, has denied the ability of PAs to bill for closed fracture care. Similarly, Novitas Solutions, the Part B MAC for Arkansas, Colorado, District of Columbia, Delaware, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas, and (Northern) Virginia has also denied the ability of PAs to bill for closed fracture care.

If you experience a denial in billing for closed fracture care, please contact AAPA's Reimbursement Department so that we can provide you with potential alternative billing options to obtain payment.

PA-Physician Relationship and Employment

According to Medicare regulations, PAs can be employed by physicians, nursing facilities, hospitals, ambulatory surgical centers, group medical practices, or corporations in which PAs have an ownership interest (See section on PA Ownership Interest.).

Medicare allows for a PA and a physician to work together collaboratively, even if each is employed by a different entity. For example, a PA can be employed by a hospital and the physician can be employed by a private group that is not affiliated with the hospital. The key is that the reimbursement and professional work product of the PA must accrue to the PA's employer, in this case the hospital.

Participating in the Medicare Program

Provider Eligibility*

According to Medicare, an individual who meets the following criteria is qualified to provide covered professional services as a PA. He or she:

- Graduated from a PA education program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation); or
- Passed the national certification examination administered by the National Commission on Certification of Physician Assistants; and
- Is licensed by the state to practice as a PA.

Effective January 1, 2003, NPs applying for Medicare provider numbers must possess a master's degree from an NP program, as well as national certification and state licensure. PAs are not required to have a master's degree.

*Medicare Benefit Policy Manual, chapter 15, section 190 A (See Section 2156 A in Appendix B.).

Medicare Enrollment

In order to enroll in Medicare, an eligible PA must obtain an NPI number and then complete an application with Medicare. Every time a PA gets a new employer, he or she must reapply to Medicare.

Obtain an NPI

You may apply for an NPI online. Complete the short application and receive your number within two weeks. If you prefer, you may complete the paper application, also available at the National Plan & Provider Enumeration System (NPPES) website, and mail to the address provided.

PAs and other professionals keep the same NPI number throughout their careers. However, if you get new employment, change your address, or change your name, you will need to update your NPI to show the new information on the NPPES website. For questions about the NPI application or update process, contact the enumerator, Fox Systems, at 1-800-465-3203 or 1-800-692-2326 (TTY). (See Appendix I for additional information on NPI numbers.)

Complete the Medicare Application Process

After you obtain your NPI, complete the enrollment process by submitting an online application at the Provider Enrollment, Chain, and Ownership System (PECOS) website. Alternatively, you may complete the paper 855I application and submit it to your Medicare Administrative Contractor (MAC). An NPI is necessary to complete the process. If you do not know your NPI, it is easily accessed from the NPI registry.

The PECOS website walks you through the application process and provides you with a two-page Certification Statement. You must then mail the original signed (blue ink recommended) Certification Statement and any supporting documents to your MAC within seven days of the electronic submission. The effective date of filing an enrollment application is the date the MAC receives the signed and dated Certification Statement. **Note: A Medicare contractor will not process an online enrollment application without the signed and dated Certification Statement.**

Medicare will allow you to see and treat patients 30 days prior to the date that they receive your application and signed certification. However, your employer will not receive payment until after Medicare has completed the processing. If there is a problem with your application, you may not be paid for claims you have submitted.

Medicare also allows enrollment exclusively for the purpose of ordering and referring. If you will not be performing professional services for Medicare patients, but anticipate ordering and/or referring for Medicare patients, enroll as an ordering and referring provider either through PECOS online, or the paper 855O form.

Opt-out

Some healthcare professionals choose to "opt out" of Medicare to be able to charge patients higher fees for services and/or avoid the administrative issues involved in the federal Medicare program. Opting out of Medicare results in healthcare professionals entering into private contracts with patients for payment, as opposed to billing and being reimbursed by the Medicare fee-for-service program. When a PA is employed by a physician, the physician may want the PA to have a similar relationship with the Medicare program. If a physician has opted out of Medicare, they may want the PA to have the same status.

Under Section 4507 of the Balanced Budget Act of 1997, Congress permitted healthcare professionals to opt out of the Medicare program. If a healthcare professional opts out of Medicare, that professional's group practice is still able to bill Medicare for the services of other professionals in the group who have not opted out. In addition, Medicare will reimburse for services provided on the order of a healthcare professional who has opted out, as long as the practitioner who provided the service has not opted out.

To protect beneficiaries, Congress made it so when a healthcare professional opts out, they remain so for the subsequent two years, and must actively express a desire for inclusion should they want to participate in the program again. The provision does permit a reversal of opting out if done so within the first 90 days, but this only applies to the first time a healthcare professional alerts CMS they will opt out, and not after the automatic renewal of status.

The required two-year period creates the potential for "job lock" for PAs and other healthcare professionals. If an opted-out PA were to leave his or her employer, employment may be difficult to find elsewhere through no decision of the PA's, but rather because they were required to opt out by their former employer. When going to a new employer, the PA retains their opted-out status.

PA-Physician Relationship Under Medicare

The physician need not be physically present with the PA when a service is being furnished to a Medicare patient, unless required by state law or facility policy.

PA Collaboration with Physicians

Generally, the Medicare program follows the PA regulations established in each state regarding the type of collaboration PAs have with physicians. In almost every instance, Medicare rules do not require that a physician be in the same physical location as the PA when the PA delivers care to Medicare beneficiaries. For Medicare, the requirement is that a PA and a physician each have access to reliable electronic communication, such as a cell phone.

The Medicare program officially uses the term supervision to describe a PA's working relationship with a physician. Because the term supervision fails to adequately describe the autonomous nature of how PAs practice, outside of the Medicare program the term is less likely to be used and is being replaced by terms such as "collaboration" that more accurately describe how PAs and physicians work together as part of integrated healthcare teams.

Co-signature

In general, Medicare rules do not require physician co-signature of charts or medical records when patients are treated by PAs, unless state law, a specific Medicare rule, or the policy of the hospital or facility specifically requires a physician co-signature. Under Medicare, a physician's co-signature is required (prior to patient discharge) when a PA writes an admission order. Medicare no longer requires a physician co-signature on a patient's chart when PAs perform preadmission or presurgical H&Ps, or on discharge summaries.

Office Billing

Offices or Clinics

Prior to 1998, PAs were able to provide medical care to Medicare beneficiaries in the office or clinic practice setting only under the "incident-to" provision, requiring the on-site presence of the physician. The only exceptions to this were in federally designated rural Health Professional Shortage Areas (HPSAs) and in certified rural health clinics (RHCs) where the physician was not required to be on site for billing purposes.

Legislative changes in the BBA 1997, which went into effect on January 1, 1998, allow PAs to treat Medicare patients in any office or clinic practice setting, with state law determining PA/physician collaboration requirements and the PA's scope of practice. The BBA 1997 allows services to be billed under the "incident-to" provision for reimbursement at 100% of the Physician Fee Schedule (as long as Medicare's enhanced regulatory requirements are met) or to be billed under the PA's NPI for reimbursement at 85%.

"Incident-to" Billing Provision

"Incident-to" is a Medicare billing provision that allows services provided by PAs in the office or clinic to be reimbursed at 100% of the Physician Fee Schedule. While "incident-to" billing provides an opportunity to maximize reimbursement, the Medicare requirements necessary to use "incident-to" billing are often misunderstood or improperly applied, which could result in paybacks and fines.

For a practice to bill for a medical service provided by a PA under the "incident-to" provision, the following criteria must be met:

- The service must be one that is typically performed in the physician's office.
- The service must be within the PA's scope of practice and in accordance with state law.
- The physician must be in the suite of offices when the PA renders the service.
- The physician must personally treat the patient and establish the diagnosis on the patient's first visit to the practice or for any established patient who comes to the practice with a new medical condition.
- The PA must represent a direct financial expense to the physician billing (W-2, leased employee or independent contractor).
- The physician is responsible for the overall care of the patient and should perform services at a frequency that reflects his or her active and ongoing participation in the management of the patient's course of treatment.

For an additional explanation of the "incident-to" provision, refer to the memo titled Medicare Reimbursement/"Incident-to" found in Appendix J1 of this guide and section 2050.2 of the Medicare Carriers Manual Transmittal 1764, found in Appendix J2.

There may be occasions when the physician who originally treated the patient is not on site when the patient comes back to the office or clinic for follow-up care for that same medical condition. Medicare generally considers physicians within the same group practice to be interchangeable for "incident-to" billing purposes. Let's say that Dr. Smith treated the patient on the first visit, performed the exam and developed the plan of care. The patient returns 3 weeks later for a visit for that same condition and is treated by a PA. If Dr. Jones, another physician in the group, is physically in the suite of offices, then the PA can perform the follow up visit "incident-to" Dr. Jones. The "incident-to" service must be billed under the name of the physician who is physically on site when the PA delivers care.

"Incident-to" Billing Provision

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If you cannot meet the guidelines of "incident-to" or believe that following "incident-to" billing is overly complicated, then virtually any Medicare-covered service may be billed using the PA's NPI with payment at 85% of the Physician Fee Schedule. PAs can treat new patients or established patients with new medical problems. In addition, when billing under the PA's NPI, the physician does not have to be on site when care is provided (unless required by state law or facility policy).

Many physicians are deciding to avoid using "incident-to" billing. They find that care can be provided more efficiently by allowing PAs to work to the top of their license and bill under their own name and NPI. The 15% payment differential for a typical office visit is often $10-$12. One extra visit by the PA or the physician (due to increased practice efficiency and both the physician and the PA running their own patient schedules) that day will likely make up for any payment differential. Physicians also understand that they avoid confusion and the potential for fraud and abuse concerns by not meeting the more restrictive regulatory guidelines associated with "incident-to" billing.

Billing in a Private Office/Clinic

If all criteria are met for the "incident-to" billing provision, the visit may be billed to Medicare under the physician's NPI. Reimbursement is made at 100% of the Physician Fee Schedule. The billing provider/group number is placed in Box 33 and the physician's NPI is placed in Box 24J of the CMS 1500 form.

If the criteria for "incident-to" are not met, the visit must be billed under the PA's NPI. In this case, the billing provider/group number is placed in Box 33 and the PA's NPI is placed in Box 24J.

Private Office/Clinic Frequently Asked Questions

Q: Can a PA see a new Medicare patient?

A: Yes, as long as the PA meets state guidelines regarding supervision and scope of practice. The visit must be billed under the PA's name and NPI, with reimbursement at 85% of the Physician Fee Schedule being made to the employer. The "incident-to" billing provision is only applicable for established patients when the physician has diagnosed the illness and established the treatment plan.

Q: Can a PA see a Medicare patient if the physician is off site?

A: Yes, as long as state law guidelines for supervision are met. The physician being off site eliminates the use of the "incident-to" billing provision, requiring the visit to be billed under the PA's NPI.

Q: What do I do in a situation where I am scheduled to see a patient for an "incident-to" visit (established patient, established condition, physician on site), and midway through the visit the patient begins to describe a new condition that is unrelated to the physician's previous diagnosis? Can I see and treat the patient for the new condition or does the physician have to see the patient?

A: In this situation, you have two options. You can see and treat the patient for the new condition but would have to bill the visit under your NPI and receive the 85% reimbursement. Or, you can have the physician treat the patient for the new problem. You could then treat the patient on a subsequent visit as "incident-to." This would allow you to bill under the physician's NPI number and receive 100% reimbursement on a subsequent visit for this new medical problem. If the physician chooses to treat the patient to establish the potential for future "incident-to" billing by the PA, then he or she needs to perform the full examination for the new problem and develop an independent diagnosis and plan of care.

The option you choose will depend on the flexibility of your office schedule. The physician may or may not have time in his or her schedule to see additional patients throughout the day. At the same time, while you are waiting for the physician to see this patient, you are occupying an examining room and also slowing down your own schedule. This determination should be made based on your office needs and demands. Many practices have found that there are increased efficiencies and reduced concerns regarding billing confusion when "incident-to" billing is not used and PAs treat patients and bill with their own name and provider number.

Q: Can I bill "incident-to" in a hospital?

A: No. The "incident-to" billing provision is only applicable in an office or clinic that is not owned or financially integrated with a hospital.

Hospital Billing

Overview

Since January 1, 1987, PAs have been covered under Medicare for services provided in hospitals. Title 42 of the U.S Code Annotated — Public Health & Welfare, Section 1395x(s)(K)(i) notes the statutory coverage of PAs in the hospital practice setting; CMS regulations for PAs make no distinction between hospital inpatient, outpatient, and emergency department practice settings.

Generally, all services for which Medicare would pay if performed by a physician in a hospital are also covered when performed by a PA. In the 1986 revisions to the Medicare Hospital Conditions of Participation (Federal Register 51, no. 116, [17 June 1986]: Section 482.12(c)) that refer to the ability of the physician to delegate patient care responsibilities to the PA, CMS states that the use of the term physician care is "not intended to restrict the ability of doctors of medicine or osteopathy to delegate tasks to appropriately qualified health care personnel such as physician assistants ... in accordance with state law."

Services delivered by PAs in hospitals are billed at the full physician rate. Reimbursement is made at 85% when billed under the PA's name and NPI number. There is no requirement for a physician to be physically on site when PAs deliver care in hospitals. Medicare simply requires that the PA and a physician have access to reliable electronic communication.

In a very limited number of circumstances, such as in a cardiac or pulmonary rehabilitation facility, Medicare requires that a physician personally be on the premises available to perform medical duties when the facility is treating patients.

Billing in Hospital Settings

Medicare Part A (also known as hospital insurance) covers inpatient hospitalization, nursing facility care, home healthcare, and hospice care (e.g., facility fees and supply costs). Part B (medical insurance) covers professional services provided by physicians, PAs, and certain other authorized practitioners in the office, clinic, hospital (including emergency room), and nursing facility.

In the past, Medicare gave hospitals two options for covering services by hospital-employed PAs. Services provided by PAs were billable under Medicare Part B as individual professional services; or, the PA's salary could be included in the hospital's cost reports and covered under Medicare Part A. Due to a change in Medicare's regulations, the option of including the PA's salary in the hospital's cost reports if that PA is engaged in providing clinical services to patients is no longer an appropriate method of coverage. Rather, PA professional services should be billed to Medicare Part B. The same rules apply to physicians and advanced practice nurses.

Shared Visit Billing – Rules for Evaluation and Management Services

In the past, Medicare rules for hospital (inpatient, outpatient, or ED) billing required that the practitioner who provided the majority of the professional service to the patient be the one that billed for the service. That is, if the PA did the majority of the work for the patient, the service should be billed under the PA's NPI and reimbursement would be at 85% of the Physician Fee Schedule. Some mistakenly believed that the service could be billed under the physician's name at 100% if the physician was on site, co-signed the patient's chart, and/or provided some minor service to the patient. That was not the case, nor can the "incident-to" billing concept be applied in the hospital setting.

For a period of time (September 2001-2002), Medicare suggested that a concept known as "split billing" be used to separately bill for evaluation and management (E/M) services provided by PAs and physicians when both provided care to the same patient on the same day in the hospital setting. After being made aware of the administrative and billing difficulties that this concept would cause for both practitioners and Medicare carriers, the split-billing concept was rescinded.

PAs and physicians who work for the same employer/entity may share visits made to patients (inpatient, hospital outpatient, or ED) with the combined work of both billed under the physician at 100% of the fee schedule (Medicare Transmittal 1776 (section 15501, B). (See Appendix K.) Therefore, if the PA provides and documents the majority of the service for the patient and the physician provides and documents all or some portion of the history, exam, or medical decision-making components of an E/M service, the entire service may be billed under the physician.

This rule does not extend to procedures performed in the hospital. The practitioner who does the majority of the procedure is the one under whom the procedure should be billed. Also, CMS does not allow critical care services/minutes to be billed as a shared visit.

The following criteria must be met for shared visit billing:

- Both the PA and the physician must work for the same entity (e.g., same group practice or hospital, or the PA is employed by a solo physician).
- The services provided must be E/M services and not procedures or critical care services.
- The physician must provide and clearly document at least some face-to-face part of the E/M visit. Simply reviewing or signing the patient's chart is not sufficient.
- The specific professional service(s) provided by the physician must be clearly documented in the patient's chart, and there must be a clear distinction between the physician's and the PA's services.
- Both the PA and physician must treat the patient on the same calendar day (not just within a 24-hour period).

If the physician does not provide and document some face-to-face portion of the E/M encounter, or if any other shared visit criteria are not met, then the service is appropriately billed at the full fee schedule amount under the PA with reimbursement paid at the 85% rate.

Medicare Administrative Contractors (MACs) vary in their definition of the shared visit billing provision. Wisconsin Physicians Service Medicare, a MAC for two Midwestern jurisdictions (J5 and J8), follows CMS policy and says the physician must complete "a substantive portion of the E/M visit" and defines substantive as "all or some portion of the history, exam, or medical decision making key components of an E/M service." Palmetto GBA (JM) states that a physician must complete a substantive portion of an E/M service, but adds that "a substantive portion of an E/M visit involves at least one of the three key components (history, examination, or medical decision making)." PAs and their practices/facilities should follow the specific requirements of their MAC when using the shared visit billing provision.

Credentialing and Privileging

Medicare's Conditions of Participation for Hospitals require that practitioners, including PAs, providing care in a hospital or other healthcare organization be privileged through the medical staff process, regardless of by whom they are employed. Privileging is the granting of authority by a healthcare organization's governing body to a PA (and other healthcare practitioners) to provide medical care services. The bylaws must state scope of privileges that may be granted, which must be in accordance

with state law, federal regulations, and applicable accreditation/deeming standards. The clinical privileges should be consistent with the PA's education, training, experience, demonstrated competency, and upon verification of the practitioner's credentials. Medicare should not be billed for any services, tests, or treatments rendered by a PA for which he or she is not authorized by state law or federal regulation or has not been granted privileges.

For hospitals accredited by the Joint Commission, the PA must also comply with Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). FPPE and OPPE are processes to establish the competence of a healthcare professional to perform services and procedures that ensure the provision of safe, high-quality patient care. FPPE is required when a PA is new to an organization, is requesting new privileges, or when a clearly defined trigger indicates the need for performance monitoring. OPPE requires ongoing performance evaluation to demonstrate competence for the maintenance of clinical privileges.

PAs Performing Hospital Admission H&Ps, Writing an Admission Order

Due to explanatory language issued by CMS dated September 5, 2013, in relation to the "two-midnight rule," it was mistakenly believed that CMS prohibited PAs from performing preadmission H&Ps or from writing admission orders. That is not the case. CMS issued a clarification on January 30, 2014 acknowledging that PAs are authorized to write the admission order and perform the H&P. Medicare rules require that a physician co-sign the admission order prior to patient discharge.

Hospital Inpatient Services Provided by a PA

Inpatient Admissions

A PA (NP/resident) may furnish the order for an inpatient hospital admission; the order must be co-signed by a physician prior to the patient's discharge from the facility. PAs may perform the inpatient admission history and physical (H&P) if granted the privileges to do so and may accordingly bill Medicare for the appropriate initial hospital care code (CPT 99221-99226).

Inpatient Rounds/Subsequent Hospital Visits

PAs may perform medically necessary subsequent hospital visits and may bill for visits (that are not otherwise included in the global surgical package) using the appropriate subsequent hospital care codes (CPT 99231-99233).

Discharge Management Services

A PA may perform discharge management services, including the discharge summary, if allowed by state law and facility policy. Discharge management includes the face-to-face E/M service, completion of discharge records including the discharge summary, prescriptions, arranging for follow-ups, and other patient management. Inpatient hospital discharge management, and subsequent reimbursement, is based on whether more or less than 30 minutes was required for discharge management services (CPT code 99238 for 30 minutes or less or 99239 for more than 30 minutes.) Therefore, the time spent performing inpatient discharge management services should be documented in the medical record.

The discharge management service may be performed as a shared visit if the physician performed and documented a portion of the face-to-face E/M service (See the section Shared Visit Billing – Rules for Evaluation and Management Services.). If all criteria are met for the shared billing provision, the service may be billed to Medicare under the physician's NPI with reimbursement at 100% of the Physician Fee Schedule. Otherwise, the discharge service should be billed under the PA's NPI with reimbursement at 85% of the Physician Fee Schedule.

A discharge summary should include a summary of the patient's stay, including: symptoms, treatments, outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. The documentation of the discharge summary may be furnished by the PA. The discharge day management visit should be reported for the date of the actual visit, not the date of discharge, if it occurs on a different calendar date.

Due to explanatory language issued by CMS for guidance to hospitals dated March 15, 2013, it was mistakenly believed that CMS required that discharge summaries performed by PAs (and NPs) be co-signed by a responsible physician within 30 days of discharge. In a correspondence to AAPA in October 2017, CMS clarified that a discharge summary does not need to be co-signed by a physician as long as the following criteria are met:

- The PA completing the discharge summary was a part of the team responsible for the care of the patient while hospitalized.
- The PA is acting within their scope of practice, state law, and hospital policy, and co-signature is not required by state law or hospital policy.
- The PA authenticates the discharge summary with his or her signature (written or electronic) and the date/time.

Observation Services

Observation Order

PAs and NPs can order outpatient services, including observation services, as long as they have been granted the privileges by the facility to do so. They may also furnish and bill the Medicare program for the initial observation services (CPT 99218-99220).

Observation Discharge Management Services

Observation discharge management services are not billed based on time. Instead, when a patient is held for observation and discharged on a different calendar date, the CPT code 99217 is used for the observation discharge service. No discharge CPT code should be reported if the patient is discharged on the same calendar date.

The discharge management service may be performed as a shared visit if the physician performed and documented a portion of the "face-to-face" E/M service (See section on Shared Visits – Rules for Evaluation and Management Services.). If all criteria are met for the shared billing provision, the service may be billed to Medicare under the physician's NPI with reimbursement at 100% of the Physician Fee Schedule. Otherwise, the discharge service should be billed under the PA's NPI with reimbursement at 85% of the Physician Fee Schedule.

A discharge summary should include a summary of the patient's stay, including: symptoms, treatments, outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. The documentation of the discharge summary may be furnished by the PA.

Payment to the Employer of the PA: Implications for PAs, Physicians and Hospitals

While there is a great deal of flexibility in the ability of PAs to work with different physicians even when there is not common employment, certain rules exist as to which entity is allowed to receive reimbursement from PA-provided services. PAs and physicians need not work for the same employer in order to work together. However, the Medicare program is clear in that only the actual employer of the PA may receive reimbursement for the PA's services. This concept also extends to the fact that only the PA's employer is able to benefit from the professional work product of the PA.

Proper arrangements must be in place (e.g., leasing agreement) for hospital-employed PAs or NPs to provide professional services to the patients of private, non-hospital employed physicians to prevent potential Anti-Kickback Statute, Physician Self-Referral ("Stark") Law, and False Claims Act violations.

For example, it would be inappropriate for a hospital-employed PA or NP to provide services such as medical histories, physical examinations, daily rounds, global post-op visits, and progress notes, and have those services captured/billed by a non-hospital employed physician. It would be as if the hospital were giving free professional "in-kind" services to the non-hospital employed physician.

Options to deal with this issue include:

- A lease or contractual agreement based on fair market value between the hospital and the non-hospital employed physician, creating an employment relationship between the physician and the PA, which permits the physician to receive reimbursement for the PA's services.
- In the absence of such an agreement, the PA's employer must receive reimbursement for the PA's services.

AAPA does not provide legal advice. Questions or concerns about this issue should be directed to a qualified healthcare attorney.

Surgery

First Assisting at Surgery

PAs who first assist at surgery are covered at 85% of the physician's first assisting fee. Medicare reimburses a physician who first assists at the rate of 16% of the primary surgeon's fee. PA first assists are therefore covered at 13.6% of the primary surgeon's fee. PAs can provide the same range of first assist duties as physicians. PAs cannot act as primary surgeons. However, they are covered as the primary provider for personally performing minor surgical procedures.

PAs should bill for their first-assist services at the full Physician Fee Schedule rate, using the -AS modifier. The use of the PA's NPI number and the surgical assistant billing modifier (-AS) will indicate to the Medicare carrier that the service should be reimbursed at 13.6% of the primary surgeon's fee. (See Medicare Claims Processing Manual, chapter 12, section 110.3.)

PAs should also be aware of the Medicare list of approximately 1,900 CPT codes for which a first assistant at surgery will not be reimbursed. These code restrictions apply to PAs, physicians and other healthcare professionals covered for first assisting under Medicare.

When Medicare's claims records show that an assistant at surgery is used less than 5% of the time nationwide for a particular surgical procedure (and the procedure is performed at least 100 times per year), that procedure is normally added to Medicare's restricted list. The list of CPT codes for which Medicare will not pay for a first assistant for 2018 is located in Appendix L1. The list is subject to change each year. The list of excluded codes is typically released by Medicare in the first quarter of the year and can be found in the Physician Fee Schedule Relative Value File on the CMS website. AAPA maintains a current concise list of restricted codes on its website and updates the list whenever new information becomes available from CMS.

Included in *The Essential Guide to PA Reimbursement* this year is a list of surgical codes that are payable, by Medicare, to a first assistant if documentation establishing medical necessity is provided (Appendix L2) and a list of surgical codes that are payable, by Medicare, to a first assistant (Appendix L3).

Occasionally, the question is asked as to whether a surgeon has to indicate/dictate the need for a first assistant for third-party payers to reimburse for the first-assist service. While there is no across-the-board requirement, it may be helpful from a reimbursement standpoint to have the surgeon use language to support the need for an assistant at surgery. No specific language has been approved for this purpose; however, the examples provided below may be useful. Always check with the individual payer for their rules/requirements.

"The skilled assistance of the PA, (insert name), was necessary for the successful completion of this case. He/she was essential for the proper positioning of the patient, manipulation of instruments, proper exposure, manipulation of tissue, and wound closure."

"Due to the complexity of the case, a first assistant was deemed necessary."

"Due to the patient's morbid obesity, with a BMI greater than 40, and resultant complexity of the case, the assistance of the PA was essential."

Preoperative H&Ps

As a general rule, Medicare does not separately reimburse for a preoperative history and physical (H&P) because it is considered part of the global surgical package. Payment for the professional work of the preoperative H&P has been added to the global fee package. If Medicare does separately cover preoperative H&Ps, it is only under specific conditions.

H&Ps may be covered separately when they are performed more than 24 hours before the surgery and when there is specific medical necessity (e.g., patient has a recent history of uncontrolled hypertension, diabetes, or some other medical condition that requires special monitoring prior to a surgical procedure). If a patient, for example, has a history of hypertension that has been well controlled or simply has three comorbidities, it is likely that the H&P would not be separately billable, as there would be no reason to expect a problem in the patient's condition or suitability for surgery. If the only reason that an H&P is being performed is because it is routinely required by the hospital, then Medicare will not separately pay for the service.

If the decision for surgery occurs on the day of or day before surgery and includes the preoperative E/M, then the visit is reportable. Modifier -57, decision for surgery, is used to denote that even though the visit occurred within 24 hours of the surgery, it is a billable service and not a general "screening" visit required by the hospital.

Data Collection on Global-Surgical Services

Previously, CMS, believing it may be excessively reimbursing for the level of service provided, expressed an intention to unbundle the global surgical package and pay separately for each portion. The MACRA legislation prohibited CMS from doing this and instead required CMS to determine a way to collect information on this issue. As a result, CMS finalized a data-collection method in its 2017 Physician Fee Schedule.

- Only practices in certain states will be required to report (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island).
- Only practices with 10 or more practitioners will be required to report.
- Practices will only report on certain high-volume services (codes reported annually by more than 100 practitioners and either reported more than 10,000 times or have allowed charges in excess of $10 million annually).

- Practices will report on postoperative services using HCPCS code 99024 (and will not be required to use G codes/time-based codes).
- The 2018 list of codes for which reporting is required on or after January 1, 2018 can be obtained from CMS.

While the final rule did exempt many practices from reporting, CMS encourages others to still report this information, should they choose to do so.

Ambulatory Surgical Centers (ASCs)

A Medicare-covered ambulatory surgical center (ASC) is a healthcare facility focused on providing same-day surgical care, including diagnostic and preventive procedures, to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission. These entities are often described as same-day surgery centers.

PAs are covered professionals for Medicare-billable services furnished in ASCs.

ASCs have fee schedules/payment systems that are separate from hospital fee schedules, and the Affordable Care Act requires that the Secretary of Health and Human Services develop a plan to implement a value-based purchasing (VBP) program for payments under the Medicare program. See the CMS website for more information its ASC payment system policy.

See Appendix M for a CMS MLN fact sheet on ASCs.

Specialized Hospital Types

Teaching Hospitals

Medicare restricts coverage for PAs, NPs, and physicians who first assist in teaching hospitals. This restriction only applies to first assisting at surgery; the presence of residents or fellows has no bearing on the ability of PAs to deliver and be reimbursed for other eligible services delivered in teaching hospitals. In general, no reimbursement payment is made for first assisting at surgery when it is provided in a teaching hospital that has an approved, accredited training program related to the specialty required for the particular surgical procedure and has a qualified resident available to perform the first-assist duties. Hospitals that only participate in the approved programs of other hospitals, or that have non-approved training programs, are not subject to these restrictions and can use and bill for a PA for the first assist.

However, there are exceptions to the requirement that qualified residents be used to perform the assist. There are times when Medicare will cover the services of a PA first assistant even if the hospital has an approved, accredited program related to the specialty. If the teaching hospital has no "qualified" resident available (i.e., resident attending a scheduled training session), or in trauma surgical cases, or if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients, then a PA can be covered for the first assist. However, to use a PA, NP, or physician for the first-assist duties because a qualified resident is "in another part of the hospital," for example, would not be appropriate.

The Medicare carrier may require that a certificate that reads as follows accompany the first assist claim:

"I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits Medicare Part B ... payment for services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were

medically necessary, and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier."

Check with your local Medicare carrier regarding this requirement.

It may also be prudent to note in the operative report the fact that the surgery required the use of a first assistant and that a qualified resident was not available, therefore necessitating the use of a PA, NP, or physician as the first assistant.

When billing for a PA first assist in a teaching hospital, some MACS require the use of both the "AS" and "82" modifiers in addition to the surgical CPT code on the CMS 1500 claim form. Check with your local MAC for their specific policy.

Critical Access Hospitals

PAs are covered when delivering care in critical access hospitals (CAHs). In general, there are two ways in which services delivered by PAs and physicians are covered:

Method I: Standard Method

Method I reimbursement for outpatient CAH services is 101% of the reasonable cost less applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to CAH outpatients is based on the fee schedule, billed charge, or other fee, as would apply if the services had been furnished in a hospital outpatient department.

For purposes of CAH payment, professional medical services are services provided by a physician or non-physician practitioner (i.e., physician assistant or nurse practitioner), which could be billed directly to Part B *on the 1500 claim form*.

In general, payment for professional medical services under the cost-based CAH plus professional services method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Method II: Optional Method

Payment for outpatient CAH services under Method II is based on the sum of the facility services and reimbursed at 101% of reasonable cost less applicable deductible and coinsurance.

The professional services are reimbursed at 115% of Physician Fee Schedule less applicable deductible and coinsurance.

CAHs bill Part A for both the facility services and the professional services furnished to its outpatients on the UB-04 form.

Additional information on CAHs can be found in the Medicare Learning Network CAH issue brief, and the MLN Matters Method II article.

Hospital-Based/Outpatient Clinics

Medicare's payment policy and supervision requirements may be confusing to PAs who work in hospital-affiliated clinics/outpatient clinics.

The clinic's physical location is not necessarily the key factor in determining whether the office or clinic is considered part of the hospital or an "independent" clinic. A clinic may still be considered part of the hospital even if it is located several miles away. In that case, coverage rules for medical services provided by PAs would be the same as for services provided in the hospital and therefore billing "incident-to" would be inappropriate, but billing as shared-visit services would be acceptable. If the clinic is owned by the hospital, then it officially is considered an outpatient clinic setting and typically must follow hospital billing guidelines.

The clinic's physical location is not necessarily the key factor in determining whether the office or clinic is considered part of the hospital or a private clinic. A clinic may still be considered part of the hospital even if it is located several miles away. In that case, coverage rules for medical services provided by PAs would be the same as for services provided in the hospital. If the clinic is owned by the hospital then it is officially considered an outpatient clinic setting and must follow hospital billing guidelines.

Medicare is currently reviewing this issue because the agency has concerns about payment policies that pay higher reimbursement to hospital-affiliated entities than to private clinics. Policymakers are questioning whether higher fees should be paid to a practice setting based upon ownership when in fact the cost of doing business as a private clinic likely did not change when the clinic was purchased by the hospital. In CMS' 2018 Physician Fee Schedule rule, the agency proposed further modification to the PFS Relativity Adjuster, which will result in cuts in reimbursement for non-excepted items and services furnished by non-excepted off-campus provider-based departments from 50% to 40% of the OPPS payment rate. CMS made this modification to establish payment parity with similar services delivered in private office settings.

Use of Scribes

PAs and physicians may use the services of scribes to assist with documentation during a clinical encounter. The scribe is present during the encounter and records in real time the actions and words of the healthcare professional as they occur. Scribes may not interject their own observations or impressions into the medical record. The PA or physician who uses the scribe is ultimately responsible for all documentation and must verify that the scribe's note accurately reflects the service provided during a patient encounter. (Note: Auxiliary office personnel (i.e., medical assistant) may provide the review of systems (ROS) and the past family and social history (PFSH), which, if reviewed by the PA or physician, can be used as part of the documentation for the encounter.)

Medicare policy allows for the use of scribes, but does not reimburse separately for the scribe's services. Payment is only made for the professional services delivered by the Medicare authorized healthcare professional. PAs practice medicine just as physicians do. It would be inappropriate and a waste of a highly educated professional's time and energy to use a PA as a scribe.

Restraint and Seclusion

Medicare policy allows PAs to initiate restraint and seclusion if certain provisions are met. PAs can provide the required (§482.13(e)(12)) face-to-face encounter (if allowed by state law and hospital policy) when restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. When a PA performs

the face-to-face encounter, he or she is required to consult the attending physician responsible for the care of the patient as soon as possible after the evaluation. CMS Interpretive Guidelines for Hospitals clarify that consultation with the physician does not need to be in person and can occur by telephone. At the time of consultation, a PA can obtain from the physician a verbal order for restraint, which would need to be co-signed according to institutional policy.

CMS Conditions of Participation §482.13(e)(5) require that the use of restraint or seclusion "be in accordance with the order of a physician or other licensed independent practitioner (LIP)." According to the Joint Commission, an LIP is someone who provides "care and services without direction or supervision" and does not include PAs or NPs in states without independent practice. Even if an NP orders restraints, CMS CoP §482.13(e)(7) states that the "attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion." Hospital policies and procedures should address the definition of "as soon as possible" and documentation in the medical record that the attending physician was notified is required.

Nursing Facilities

Medicare covers services provided by PAs in nursing facilities (NFs) or skilled nursing facilities (SNFs), but with some caveats.

Nursing Facilities Services Covered

In general, services for which Medicare provides reimbursement if performed by a physician are also covered when provided by a PA within their scope of practice. Medical services provided by PAs delivered in SNFs are reimbursed at 85% of the Physician Fee Schedule. Typically, SNFs are reimbursed under Medicare and NFs are reimbursed by state Medicaid programs.

Medicare authorizes PAs to certify and recertify the need for SNF care. However, Medicare requires that certain medical duties in SNFs be performed by a physician only. Medicare regulations state that in an SNF, a task may not be delegated to the PA when any regulations specify that it must be performed by the physician personally or when delegation to a PA is prohibited by either state law or the policies or regulations of the nursing facility. A complete copy of Medicare's nursing facility guidelines, also known as Nursing Facility Conditions of Participation, may be obtained from your MAC or from AAPA. A detailed explanation of Medicare's SNF and NF coverage policy can be found in Appendix N.

Medicare authorizes PAs to certify and recertify the need for SNF care.

In NFs, which are typically reimbursed by Medicaid, PAs may perform those tasks that Medicare regulations state must be performed by the physician, if allowed by state law. However, if the PA is an employee of that NF and is also performing these "physician-only" tasks, coverage is not allowed. Medicare coverage is allowed when a PA is an employee of the NF and is performing other medically necessary duties that are not designated as "physician-only" services.

When the PA is performing an NF or SNF visit, CMS allows the PA to write, sign, and date all progress notes and does not require the physician's co-signature (42 CFR §483.30(e)).

Nursing Facilities Visits

The initial comprehensive evaluation must be performed by the physician. However, the PA may treat the patient prior to the initial comprehensive evaluation if medically necessary. Because

Medicare billing system edits expect to have the first SNF visit be the comprehensive visit, submitting a bill for a new SNF visit before the comprehensive visit is billed may result in a payment rejection. AAPA reimbursement staff has been told verbally that if a visit occurs prior to the comprehensive visit it should be billed as a subsequent SNF visit. Check with your local MAC to determine if this is still appropriate policy.

Even if a PA treats a patient prior to the comprehensive visit, the physician is still required to personally perform the comprehensive visit and verify orders that may have been written by the PA. After the comprehensive visit, the PA and physician may alternate required visits. Medicare requires that the patient be seen at least once every 30 days for the first 90 days, and then every 60 days thereafter. A visit is considered timely when it occurs no later than 10 days after the date that the visit was required. Each visit, whether performed by the physician or the PA, must be face-to-face and not simply an on-site review of the patient's chart.

Visits in excess of the required visits are covered if warranted by the patient's medical condition. These additional visits can be performed exclusively by the PA and will not affect the alternating schedule already established for the required visits. Medicare generally allows up to 18 visits per year. In certain cases, Medicare may allow more than 18 visits per year. These special cases normally require a high degree of documentation.

The rules and regulations listed above apply to CMS' coverage policy. Always check with your individual state and NF for their specific guidelines.

Nursing Facilities Billing

All medical services provided by a PA in an NF must be billed in accordance with the state Medicaid agency's PA billing policy. Medicare reimbursement is made to the PA's employer at 85% of the Physician Fee Schedule. Medicaid nursing facility reimbursement varies by state.

The Medicare "incident-to" billing provision is not applicable in this practice setting. If a service or visit is to be billed under the physician's provider number, the physician must personally provide care to the patient.

Nursing Facilities Frequently Asked Questions

Q: Are PAs covered by Medicare for services provided in NFs and SNFs?

A: It is important to make a distinction between SNFs and NFs. Medicare covers medical services provided by PAs when performed in an SNF. The reimbursement level for care delivered in SNFs is 85% of the Physician Fee Schedule. Reimbursement is paid to the employer of the PA. NFs, which are typically covered by state Medicaid plans, may have a different set of rules and payment policies as compared to Medicare-covered SNFs.

Q: What types of services can PAs perform in NFs and SNFs?

A: In general, those services for which Medicare would reimburse if provided by a physician would be covered (at the 85% level) if performed by a PA. There are exceptions, though. An SNF task may not be delegated when any regulations specify that the task must be performed by a physician, or when delegation is prohibited under state law or by the policies of the nursing facility. Check with your individual state and nursing facility for specific guidelines. PAs are authorized to perform those services identified as physician-only in NFs, not SNFs, if allowed by state law, facility rules, and the Medicaid plan.

Q: Can the PA write, sign, and date orders and progress notes? Is a co-signature required by the physician?

A: At each visit performed by the physician, the physician must write, sign, and date all of his or her orders and progress notes. However, when the SNF visit is delegated by the physician to the PA, CMS allows the PA to write, sign, and date orders and progress notes. Medicare does not require that the physician co-sign the PA's orders or progress notes, except when the PA treats the patient prior to the initial comprehensive visit. However, individual state law or the regulations of the nursing facility may require a physician to personally write, sign, and date orders and progress notes or co-sign the PA's orders or notes.

Q: Are the physician and the PA required to alternate visits to the skilled nursing facility patient?

A: Yes, for required visits. The medical care of each SNF patient must be continually managed by the physician. The PA can see the patient if medically necessary prior to the initial comprehensive evaluation. After the comprehensive evaluation, Medicare requires that the patient be seen at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. The physician and PA must alternate every other of these required visits. This requirement to alternate applies to required visits. For additional visits, see the question below.

Q: Do additional visits that arise because of a change in the patient's condition or because they are warranted by the patient's medical needs need to be alternated with a physician?

A: Medicare will cover additional visits (over and above the required visits) to SNF patients if these visits are warranted by the patient's medical condition. Visits in excess of the required visits can be performed exclusively by the PA. There is no Medicare requirement that these additional visits be alternated between the PA and the physician. Nor do they affect the established alternating visit schedule.

Q: May a PA order a post-hospital SNF stay?

A: Yes, PAs not employed by the facility are authorized to provide the initial certification and periodic recertification of SNF care per 42 CFR § 424.20(e)(2). PAs not employed by the facility are authorized to certify and recertify NF care as allowed by state law.

Care Delivered in a Patient's Residence

PAs are covered when providing medically necessary services to Medicare beneficiaries in a patient's residence. This coverage refers to medical care delivered in the patient's home and not "home health services" provided to homebound beneficiaries. State law determines coverage requirements, and reimbursement is at the rate of 85% of the Physician Fee Schedule.

For services provided in the residence, the beneficiary does not need to be confined to the residence. Medicare states that the medical record must document the medical necessity of the visit to the residence made in lieu of an office or clinic visit. Therefore, there must be a reason that care is being provided in the patient's home, such as mobility issues or lack of access to transportation.

On the other hand, the term "home health services" typically refers to services delivered through a home health agency to homebound patients. At present, only a physician may certify or recertify a patient's eligibility for home healthcare and sign the patient's plan of care. One of AAPA's top legislative goals is to have legislation passed that allows PAs to certify the need for home health

services and sign the plan of care.

As a condition of payment for home health services, the Affordable Care Act mandates that, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed practitioner, has had a face-to-face visit with the patient. PAs are authorized to provide that face-to-face visit, but the physician must still certify eligibility for the home health benefit and sign the plan of care. **Note**: The face-to-face "visit" may be performed via telemedicine if Medicare's telemedicine policy is met.

PAs are covered when performing certain services for home health patients after the physician certification, such as coordination of care, review of lab tests and studies, and assessment of care decisions with other healthcare professionals and family members when utilizing the care plan oversight (CPO) codes. CPO codes (99374-99380) are time-based codes and reflect the time devoted to these activities on behalf of the beneficiary within a 30-day period.

The Quality Payment Program

The Quality Payment Program (QPP) has initiated one of the most dramatic changes in decades in how the Medicare program reimburses for care. The QPP, which went into effect on January 1, 2017, seeks to introduce a comprehensive, value-based health delivery and payment system within the Medicare program by incentivizing certain types of clinical practice behaviors. The program will either reward those professionals who meet CMS imposed standards for quality, effective use of electronic health records, practice improvement activities, and cost, or penalize those professionals who fail to do so. Although the QPP began January 2017 in terms of certain healthcare professionals having to meet program requirements and metrics, the actual financial impact of those bonuses or penalties will affect Medicare payments paid in 2019. For the 2018 performance year, reimbursement implications will be seen in 2020.

Why does successful participation in the QPP matter?

First, Medicare payments will be impacted by how healthcare professionals are rated on QPP measures and metrics. In 2019 there could be a 16% difference in income between high- and low-performing professionals under the Merit-based Incentive Payment System (MIPS). That reimbursement differential could potentially increase to 36% by 2022. Extraordinary performers can potentially receive an even higher bonus based on program criteria.

Second, each MIPS-eligible professional's MIPS score and individual category scores will be available on the Physician Compare website. The site will be publicly accessible. Patients, potential patients, employers, and others will be able to see healthcare professionals rated compared to one another on the site.

Who Is Included?

PAs are one of three healthcare professional groups, along with physicians and advanced practice nurses, that immediately qualify as eligible clinicians (ECs) and may be required to participate in one of two reporting and reimbursement tracks: MIPS or an Advanced Alternative Payment Model (Advanced APMs). Other healthcare professionals are scheduled to be included later.

Healthcare professionals who are in their first year of enrollment in Medicare, fall below a low-volume threshold, or who participate in Advanced APMs, are not included in MIPS.

MIPS and APMs

MIPS is the program option in which most healthcare professionals will begin. It replaced the Physician Quality Reporting System (PQRS), the value-based modifier, and the Medicare EHR Incentive Program. Under MIPS, ECs are reimbursed according to a composite score when compared with the scores of other healthcare professionals. An EC's composite score in 2017 was made up of scores in three categories: quality (formerly PQRS), practice improvement activities, and advancing care information (formerly meaningful use). A fourth category, cost (formerly value-based modifier), was not included in the composite score for the first year. However, 'cost' will begin to be evaluated in the 2018 performance year.

The Advanced APM track is designed for providers who are already participating in approved value-based care models such as the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus model, Medicare Shared Savings Program tracks 2 and 3, a Next Generation ACO Model or the Oncology Care Model. From 2019 to 2024, in addition to the financial incentives for being an APM, Qualified Participants (QPs) in an Advanced APM will receive an annual 5% lump-sum bonus based on Medicare Part B payments.

Low-volume Threshold

CMS allows those healthcare professionals who treat a limited number of Medicare beneficiaries to avoid participation in the QPP. Clinicians with less than or equal to $90,000 in allowed Medicare charges or less than or equal to 200 unique Medicare patients, fall below the low-volume threshold and are not permitted to participate. CMS suggests that as many as 63% of clinicians currently billing Medicare Part B will be exempt from participating in MIPS due to the low-volume threshold and other exclusions.

Next Steps

The 2016 election has introduced a level of uncertainty into the healthcare arena and may impact future policies surrounding MIPS and APMs. At this point, healthcare professionals should proceed based on the current policies as put forth by CMS.

As a practicing PA, you need to consider how best to be part of the conversation within your practice or hospital regarding QPP participation. Consider the following:

- Who in your organization is leading the QPP effort?
- How do you ensure a seat at the table to discuss QPP participation?
- Is this also an opportunity to review and discuss appropriate PA billing and reimbursement, in general?

AAPA has developed a MACRA/QPP web page with an FAQ to provide additional information on the program. For more information on the QPP, go to the CMS QPP website.

Coverage Issues

Diagnostic Tests

PAs are covered by Medicare when they personally perform a wide range of diagnostic tests as authorized by state law. While Medicare assigns a level of required physician supervision for each test, the Code of Federal Regulations §410.32 states that, "diagnostic tests performed by a physician assistant (PA) that the PA is legally authorized to perform under state law require only a general

level of physician supervision" (See Appendix E.). General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Use of the term "supervision" elsewhere in this section refers to physician supervision of technicians and other personnel who are performing or assisting in the performance of diagnostic tests and does not apply to PAs.

PAs are authorized to order and/or personally perform virtually all Medicare-covered diagnostic tests.

Language in CFR §410.32 goes on to say that "Nonphysician [*sic*] practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under state law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries for the purpose of this paragraph."

Medicare rules do not authorize PAs (or NPs) to supervise other professionals in the performance of diagnostic tests. Auxiliary personnel performing tests requiring a direct or personal level of supervision would need to have a physician providing supervision. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room. Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

(A listing of individual diagnostic procedures and the required levels of supervision can be found in Appendix O.)

While PAs may use the services of auxiliary personnel when performing diagnostic tests, the PA would not be able to leave the room in which the diagnostic test is being performed. Similar policies apply to NPs.

Upon CMS request, the ordering PA or physician must provide the following information:

- Documentation of the order for the service billed (including information sufficient to enable CMS to identify and contact the ordering physician or nonphysician [*sic*] practitioner).
- Documentation showing accurate processing of the order and submission of the claim.
- Diagnostic or other medical information supplied to the laboratory by the ordering physician or nonphysician [*sic*] practitioner, including any ICD-10-CM code or narrative description supplied.

Durable Medical Equipment

For many years, PAs have been authorized to write the order and sign the certificate of medical necessity for durable medical equipment (DME) items prescribed to Medicare beneficiaries. There was no need for a patient visit to occur within a certain time prior to the DME order. Nor was there a need for physician involvement in the DME order.

However, as a requirement for payment under Medicare, language contained in section 6407 of the Affordable Care Act (ACA) mandates that a physician, PA, NP, or CNS have a face-to-face encounter with a Medicare beneficiary to assess that patient's need for DME. The visit must occur within the last six months before writing an order for certain DME items.

Section 6407 also contained a requirement that a physician personally document the fact that the

encounter had occurred prior to the DME prescription being written. AAPA was strongly opposed to this physician documentation requirement and was instrumental in having CMS delay implementation of the requirement. Later, language in Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended to PAs and NPs the ability to document that the face-to-face visit had occurred. PAs are authorized to perform the visit, document the visit occurred and write the prescription for DME with no direct physician involvement.

The requirement of a face-to-face encounter applies to the following DME categories*:

- Transcutaneous electrical nerve stimulation units
- Roll-about chair
- Oxygen and respiratory equipment
- Hospital beds and accessories
- Cervical traction
- Any item that appears in the durable medical equipment, prosthetics, orthotics and supplies fee schedule with a price ceiling at or greater than $1,000

The full list of 167 applicable DME items can be found in Appendix P.

*__Note__: A face-to-face encounter has already been a requirement for power wheelchairs for quite some time (See the CMS Program Integrity Manual, chapter 5 – Items and Services Having Special DME Review Considerations §5.9.2.). This new rule does not apply to power mobility devices and does not change the rules currently in place for them (including the 45-day requirement).

Mental Health Services

PAs are among the healthcare professionals who are eligible under Medicare Part B to furnish outpatient diagnostic and/or therapeutic treatment for mental disorders, as allowed by state law. With enactment of the Medicare Improvements for Patients and Providers Act of 2008, the amount of a patient's copayment for mental health services will be 20%, as is the case for other medical care. Medicare has produced a resource booklet dealing with mental health services and coverage policy.

Commercial payers present a reimbursement challenge to PAs working in mental health. Some of the mental and behavioral health companies will not recognize or reimburse PAs within their networks unless the PA has advanced training or a degree in a mental health specialty. This policy is especially frustrating given the severe shortage of mental healthcare professionals in many communities throughout the country. AAPA is actively working to reduce the barriers to coverage for PAs within certain behavioral health companies.

Preventive Services

In addition to authorizing a new prescription drug benefit, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 expanded Medicare's preventive benefits. The ACA further expanded these preventive benefits and requires Medicare to offer certain services to beneficiaries free of charge (no deductible or copayment), as long as certain frequency standards are met.

These services include:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
    - Fecal occult blood test
    - Flexible sigmoidoscopy
    - Colonoscopy
    - Depression screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shot
    - Sexually transmitted infections screening and counseling
- Diabetes screening
- Flu shots
- Hepatitis B shots
- Tobacco use cessation counseling
- "Welcome to Medicare" preventive visit (one time)
- Yearly "wellness" visit

More information on these services can be found on the Medicare website.

All newly-enrolled Medicare beneficiaries are eligible to receive an initial physical examination as well as any cardiovascular screening blood tests and diabetes screening tests needed. The Initial Preventive Physical Examination, or "Welcome to Medicare" physical, allows providers to evaluate patients' blood pressure and weight, and gives providers the opportunity to educate and counsel patients on their medical status and refer them to related preventive services covered by Medicare. Under the ACA, beneficiaries can receive this and other annual wellness visits at no cost to them.

Diabetes Self-Management Training (DSMT)

Section 4105 of the Balanced Budget Act of 1997 authorized Medicare coverage of DSMT when the services are provided by a certified provider who meets certain quality standards. The program is designed to educate beneficiaries in diabetes self-management through instruction in:

- Blood glucose self-monitoring
- Diet and exercise
- Insulin treatment plan for insulin dependent patient
- Motivation to use self-management skills

PAs and other qualified Medicare practitioners managing a beneficiary's diabetic condition must certify the need for the services in order for them to be covered by Medicare. PAs, and other qualified Medicare practitioners in this role, must maintain the plan of care in a beneficiary's medical record along with documentation substantiating the need for training. The DSMT order must include a signed statement by the PA or other qualified Medicare practitioner that the service is needed, and:

- The number of initial or follow-up hours ordered (fewer than 10 hours of training may be ordered).
- The training topics to be covered (initial training may be used for full training program or specific topics like nutrition or insulin training).
- An individual or group training determination.

The PA or other qualified Medicare provider must maintain documentation, in the patient's record, that includes the original order and special conditions noted.

Medicare Part B covers 10 hours of DSMT for a beneficiary with a diabetes diagnosis. Diabetes mellitus, a condition of abnormal glucose metabolism, is characterized by:

- A fasting blood glucose level of greater than or equal to 126 mg/dL on two different days.
- A two-hour glucose tolerance blood level of greater than or equal to 200 mg/dL on two different days.
- A random blood glucose level of greater than 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Documentation of a beneficiary's diabetes is maintained in a beneficiary's medical record.

CMS designates all providers and suppliers that bill Medicare for other individual services as certified. The American Diabetes Association, the American Association of Diabetes Educators, or the Indian Health Service must certify DSMT programs. PAs that provide the service may bill as long as beneficiary qualifications are met and their employer (program) is certified. Certified programs must submit a copy of their accreditation certificate to their MAC.

Medicare beneficiaries may receive follow-up DSMT each calendar year after the year in which they are certified in need of DSMT. They may receive follow-up DSMT, when ordered, without documentation that initial training has been received. PAs designated as certified DSMT providers may bill for DSMT in an accredited DSMT program. Separate payment is not made for DSMT in RHCs, but the service is considered included in the all-inclusive rate. DSMT may be provided and billed for in Federally Qualified Health Centers (FQHCs) in addition to one other visit the beneficiary had during the same day.
The initial year of DSMT extends for 12 months following the initial date. Initial training is covered by Medicare when the following conditions have been met:

- The beneficiary has not received initial or follow-up training (HPPCS G0108 or G0109).
- Training occurs within a continuous 12-month period.
- Training is less than or equal to 10 hours (any combination of half-hour increments).
- Training is usually provided in a group setting, including non-Medicare patients, with the exception of one hour of individual training.
- One hour of individual training may be used for any part of training.

Follow-up training may occur under the following conditions:

- At most two hours of individual or group training per beneficiary per year
- Group training consists of two to 20 individuals who need not all be Medicare beneficiaries.
- Follow-up training for subsequent years may occur during a 12 month calendar period following completion of the full 10 hours of initial training.
- Follow-up training is delivered in increments of at least one half-hour.
- The PA or other qualified practitioner treating the beneficiary must document in the medical record that the beneficiary is diabetic.

Certain conditions must be met for Medicare to pay for individual training. Those conditions are:

- No group training is available within 2 months of training order
- Beneficiary's PA or other qualified practitioner documents in the medical record that the beneficiary has special needs resulting from conditions such as vision, hearing or language limitations
- PA or other qualified practitioner orders additional insulin training
- PA or other qualified practitioner indicates need of individual training in order/referral

DSMT may not be provided "incident-to" under a PA or another qualified Medicare practitioner. (See Appendix Q.)

Hospice

Beginning January 1, 2019, PAs will be authorized to provide/manage hospice care services for Medicare beneficiaries who have elected the hospice benefit. Language in the Bipartisan Budget Act of 2018 designated PAs as "attending physicians" for the purposes of Medicare's hospice benefit. This designation enables PAs to deliver care directly related to the medical condition that qualified the patient for hospice care. PAs will be able to develop and review care plans, order medications for pain relief, and otherwise participate in the ongoing care of their patient who has elected the hospice benefit. PAs will also be able to be employed by the hospice organization and have their services covered when billed to Medicare.

This change will not allow PAs to order hospice or certify/re-certify terminal illness for hospice. Only physicians are able to perform those tasks under Medicare. AAPA continues to work to remove hospice limitations for PAs.

For a number of years PAs have been able to provide medically necessary services to hospice patients for medical problems not directly related to the medical condition that qualified the patient for hospice care and bill Medicare Part B.

Chronic Care Management

As of January 1, 2015, Medicare makes a separate payment for non-face-to-face care coordination services for Medicare beneficiaries with multiple (two or more) chronic conditions, which applies to approximately two-thirds of the entire Medicare beneficiary population. The appropriate CPT code for chronic care management (CCM) is 99490, to be used in conjunction with face-to-face services, and is defined as:

> "Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored."

PAs are eligible to bill using this code. CMS also made an exception to Medicare's "incident-to" rules indicating that clinical staff can provide CCM services incident-to the services of an appropriate practitioner under general supervision, instead of direct. Only one healthcare professional may be paid for the CCM service per patient for a given calendar month. CCM code 99490 should not be used while

simultaneously billing 99495 and 99496 for transitional care management services. Around-the-clock access and continuity of care requirements also apply. Finally, a healthcare professional must inform a patient of the availability of CCM and obtain consent for the CCM service.

CMS provides additional information and details on chronic care management requirements.

Smoking Cessation

Since 2005, CMS has determined that smoking and tobacco use cessation counseling is reasonable and necessary for individuals who use tobacco and have a disease or an adverse health effect that is linked to tobacco use, or who are taking a therapeutic agent whose metabolism or dosing is affected. Two cessation counseling attempts, or up to eight face-to-face cessation counseling sessions, are allowed every 12 months. Payment is allowed for a medically necessary E/M service on the same day as the smoking cessation counseling service when clinically appropriate. Use HCPCS 99201-99215 to report an E/M service with modifier 25 to indicate that the E/M service is a separately identifiable service from smoking cessation. PAs are authorized to provide smoking and tobacco use cessation counseling.

Since August 2010, CMS has covered tobacco cessation for outpatient and hospitalized Medicare beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease, are competent and alert at the time that counseling is provided, and when a qualified physician or other Medicare-recognized practitioner, such as a PA, furnishes counseling.

Two HCPCS codes, 99406 (3-10 minutes) and 99407 (more than 10 minutes), are used for tobacco cessation counseling.

Advanced Care Planning

In CMS' 2016 Physician Fee Schedule rule, the agency declared two HCPCS codes (99497 and 99498), which would reimburse a "physician or other qualified healthcare professional," for advanced care planning, to include discussion of advanced directives. Recognizing the importance of these conversations, and the time it may take to explain, discuss, and help fill out forms, code 99497 covers the first 30 minutes, and code 99498 will cover subsequent 30-minute intervals.

PAs are qualified professionals and covered under Medicare when they have discussions with their patients regarding medical options and appropriate, personalized courses of treatment. In the 2017 Physician Fee Schedule rule, CMS recognized the value of providing these same services (HCPCS codes 99497 and 99498) via telehealth. PAs are covered when delivering this care via telehealth (See Appendix R).

Outpatient Physical Therapy, Occupational Therapy, and Speech Language Pathology (PT/OT/SLP)

Outpatient physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) services provided to a Medicare beneficiary by a participating provider are payable under the following conditions:

- PAs' or other qualified Medicare practitioners' certification and recertification
- Beneficiary is under the care of a PA or other qualified Medicare practitioner
- Outpatient PT, OT, or SLP is provided under a plan of care
- Services are provided on an outpatient basis.

Certification of PT, OT, and SLP requires that:

- The services are medically necessary to treat the patient's condition.
- The plan for providing services is or was established (put in writing) by a PA, physician, nurse practitioner or qualified physical therapist, occupational therapist, or speech language therapist.
- The PA, physician, or nurse practitioner must periodically review the PT, OT, or SLP treatment plan.
- The outpatient PT, OT, or SLP patient must be under the care of a PA, physician, or nurse practitioner.

The treatment plan includes the type, amount, frequency, and duration of services. The same PA, physician or nurse practitioner who established or reviews the plan of treatment is the one who certifies the necessity for the services. The MAC obtains the certification at the time of the plan of treatment or as soon as possible after establishment of the plan of treatment.

Recertifications occur at intervals of 30 days from the date last seen by the PA, physician, or nurse practitioner. If the PT, OT, or SLP services extend past 60 days, there must be evidence in the patient's record that a PA, physician, or nurse practitioner has seen the patient within 60 days after initiation of therapy and every 30 days past the 60th day for services to be covered. Recertification occurs at the same time the plan of treatment is reviewed. Although Medicare provides no specific forms for certification and recertification, the MAC must be able to determine that the certification and recertification requirements were met. Delayed certifications and recertifications must include an explanation for the delay and other necessary evidence. For more information on PT/OT/SLP services, see the Medicare Benefit Policy Transmittal 5 found in Appendix S.

Cardiac, Intensive cardiac and Pulmonary Rehabilitation Programs

Beginning January 1, 2024, PAs will be authorized to supervise cardiac, intensive cardiac, and pulmonary rehabilitation under Medicare. These services are medically directed and supervised programs designed to improve a patient's physical, psychological, and social functioning. Currently, only physicians are authorized to supervise these services. Language in the Bipartisan Budget Act of 2018 authorized PA supervision of these services, but delayed the start date until 2024.

Billing Process

CMS 1500 Health Insurance Claim Form

The Medicare 1500 health insurance claim form, also known as the Uniform Health Insurance Claim Form, is used to bill for services provided to Medicare beneficiaries. A sample of the 1500 claim form appears below. A number of commercial insurance companies also use this form. This form is used to bill for services provided by PAs, physicians, and other practitioners; however, some differences exist in how it is filled out. PAs should be aware of the following:

- Line 24 (section D) is the appropriate location for the CPT and modifier codes. A modifier code is used when PAs first assist at surgery. The box for the CPT code is on the left and the box for the modifier code is to the right.
- Line 24 (section F) is where the actual charges are recorded. Do not discount the charge for PA services provided in any setting. The MAC will perform that task.
- Line 24 (section J) is where the PA places his/her NPI when he/she is billing as rendering provider.

- Line 25 requires the tax identification number of the PA's employer.
- Line 31 is for the PA's signature and credentials.

MACs may have unique requirements for filling the CMS 1500 form. Please check with your MAC to make sure you are completing the form appropriately.

A list of Medicare MACs with contact information can be found in Appendix T1 of this book. A map showing the MACs state-by-state coverage is available in Appendix T2.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Current Procedural Terminology Codes

Developed by the American Medical Association, the Current Procedural Terminology (CPT®) coding system is a compilation of descriptive terms and identifying codes for reporting medical, surgical and diagnostic services and procedures. The CPT coding system provides a uniform "language" or nomenclature used to describe medical services to other medical providers, third-party payers, health researchers, and others. The five-digit CPT coding system describes more than 8,000 medical and surgical services and procedures that are delivered to patients.

Officially adopted by Medicare in 1983, the CPT system became part of CMS' Common Procedure Coding System (HCPCS). CMS then required that the HCPCS be used to report all Medicare Part B services. Three years later, in 1986, CMS mandated that all state Medicaid agencies use the HCPCS coding system in their Medicaid programs. By July 1987, CMS required the use of CPT for reporting outpatient hospital surgical procedures. In addition to the federal programs already mentioned, commercial insurance companies also use the CPT coding system.

Previously, in the CPT manual, the word "physician" appeared in numerous code descriptors. Phrases such as "the physician usually spends 20 minutes with the patient..." led some to believe that only a physician could report and perform the service associated with that particular code. That was never true. The AMA has repeatedly stated that CPT describes medical and surgical procedures and does not determine who may use the codes. That determination is left to state law and payer policies. Nevertheless, AAPA works to replace such archaic language in favor of more inclusive terminology.

To further illustrate that fact, language in the CPT manual now states:

> "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician. A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service."

Originally designed to describe only physician services, the CPT coding system has been expanded to include those services provided by a number of other practitioner groups, such as physical and occupational therapists, psychologists, optometrists, speech language pathologists, and others. To facilitate that effort, the American Medical Association's Board of Trustees concluded in 1992 that a Health Care Professionals Advisory Committee (HCPAC) should be established. The purpose of the HCPAC is to review the CPT coding system and consider the addition or revision of codes to ensure that the services provided by various non-MD/DO healthcare professionals are adequately reflected. The HCPAC, which is primarily made up of non-MD/DO professionals, including PAs, also has physician participation. The HCPAC is divided into the CPT HCPAC and the Relative Value Scale Update Committee (RUC) HCPAC. The CPT HCPAC concentrates on reviewing the suggested addition or revision of non-MD/DO CPT codes, and the RUC HCPAC works to develop relative values to assign to those codes.

Because PAs provide physician medical services, they are largely unaffected by the HCPAC process. However, a PA serves on both the CPT and the RUC HCPAC.

ICD-10

The shift to the International Classification of Diseases (ICD) 10 is one of the most significant coding changes that healthcare professionals have experienced. This change in diagnosis coding has

required a considerable effort by practitioners, practices, coders, and other stakeholders.

As of October 1, 2015, healthcare professionals and practices are required to submit claims to all public and commercial third-party payers using the ICD-10 coding system to list patient diagnoses. Failure to use an appropriate ICD code risks causing claims to be delayed or denied.

The ICD-10 system, which is already in use by nearly every other industrialized country, means a five-fold increase in the number of diagnosis code choices available, as compared to the previous ICD-9 system. ICD-9 had approximately 14,000 codes, while ICD-10 includes about 69,000 codes. One reason for the large increase is that ICD-10 provides greater specificity about patient care and allows those interested in outcomes and research to obtain additional information about the patient's complaint. For example, instead of one code for otitis media, ICD-10 provides three separate codes for right ear, left ear, or bilateral. A number of codes have been added to reflect initial or subsequent visit.

As with ICD-9, healthcare professionals do not have to learn all of the codes. Most only need to be familiar with a subset of codes that affect the specialty in which they work.

Some suggest that ICD-10 goes too far in offering potential diagnosis codes. They might offer as evidence that there is an ICD-10 code for being "sucked into jet engine, subsequent encounter" (V97.33XD).

However, on a more serious note, there are some very practical reasons why increased granularity and detailed reporting is necessary. For example, under ICD-9, which was over 35 years old, there was no code for the Ebola virus disease. Tracking the disease with ICD-9 required the use of code 078.89 (other specified diseases due to viruses). ICD-10 has a unique code for Ebola virus disease (A98.4). Increased specificity is expected to clinically assist in addressing complications, enhance communication, and better individualize care. Finally, more detail will allow for greater comparison of data, especially internationally.

Understanding ICD-10 will help you better comply with current and future reimbursement requirements.

Modifier Codes

For surgical services provided by PAs as a first assistant at surgery in a hospital or ambulatory surgical center, Medicare requires the use of a modifier code. The same CPT code that would be used by a physician for the procedure being performed is inserted in Box 24D on the standard CMS 1500 claim form, followed by the -AS modifier code, which is placed in the box marked "modifier." A few MACs may require the -80 and the -AS modifier. Verify the payer policy before submitting a claim.

PA-specific modifier codes are only used for first assisting at surgery. Commercial payers and state Medicaid programs determine the particular modifier used when PAs first assist at surgery. Do not assume that Medicare's first assisting at surgery modifiers apply to Medicaid and commercial payers. Those programs may use the -80, -81, -82 or -AS modifiers. Check with the particular payer for their guidelines.

It should be noted that PAs are fully authorized to use other modifier codes that physicians use, such as -24, unrelated E/M service by the same physician or other qualified healthcare professional during a postoperative period, and -25, significant, separately identifiable E/M service by the same

physician or other qualified healthcare professional on the same day of the procedure or other service.

Appealing Medicare Denials

If you believe that you were denied payment because your MAC did not understand your scope of practice as determined by state law, appeal the denial by following Medicare's five-level appeals process. The first two levels of appeal are internal and external reviews of the claims submission and typically do not review your scope of practice. At the third level of appeal, an administrative law judge (ALJ) will examine Medicare's policy and your scope of practice as defined by state law. To be considered at the third level of appeal, information supporting coverage of your service by Medicare should be submitted by the second level of appeal.

A successful appeal at the third level will show that the denied service is within the PA's scope of practice, and that Medicare's policy is to cover PAs for services within their state law-defined scope of practice, per Medicare Benefits Policy Manual, chapter 15, section 190 B. Submit a copy of this section with your appeal so that the ALJ understands Medicare's policy with respect to coverage of professional services provided by PAs. To show that the service is within your state's legally defined scope of practice, submit: (1) the summary of your state law and regulations regarding PA scope of practice; (2) evidence of your education and training in the service; (3) your practice agreement, including the service being denied; and (4) a letter or memo from your collaborating physician in which he or she expresses confidence in your ability to proficiently provide the service. As an alternative to the four pieces of documentation above, a ruling from the state medical board would verify that the service is within your state law-defined scope of practice. There's no guarantee, but with the above information, the ALJ has enough information to sanction payment for your services if warranted.

If you continue to be denied payment after the third level of appeal, you may appeal up to two more times provided that timeliness and monetary minimums are met. Address the reason for denial as specifically as possible.

Please notify AAPA's Reimbursement Advocacy Department of any Medicare denials based on scope of practice. AAPA compiles and tracks such denials for potential advocacy action.
For Medicare guidance on the appeals process, see Appendix U.

Fraud and Abuse

Fraud is intentional deception or misrepresentation of services that the individual knows to be inappropriate or illegal and that could result in unauthorized reimbursement to the practice. Abuse relates to negligence or the allowance of activities or actions that are not supported by good medical or practice guidelines.

Numerous state and federal agencies and departments have an interest in finding and combating fraud and abuse activities. Whether it is the Office of the Inspector General for the Department of Health and Human Services, recovery audit contractors, or Comprehensive Error Rate Testing contractors, the government is activating increased resources to deal with fraudulent healthcare behavior. Provisions in the ACA allow for the imposition of new civil monetary penalties for persons who fail to follow Medicare's program integrity rules. Lack of attention to proper billing rules can lead to the recoupment of reimbursement, fines, jail time, and exclusion from participating in federal healthcare programs. The healthcare professional that enrolls in the federal program is ultimately responsible for the billing activities concerning the patient he or she treated.

CMS has a detailed publication that can help educate healthcare professionals on fraud and abuse issues. See Appendix V.

Special Employment Statuses

Independent Contractors

For business-minded PAs, becoming an independent contractor can offer increased freedom of choice as to where, when, and how you work, more income growth opportunities, and greater latitude in deducting certain expenses and funding large retirement benefits. On the downside, you could see an increase in your work hours and a decrease in benefits and vacation time, and you will be paying self-employment taxes, professional liability premiums, and equipment costs, as well as all the "fringe benefits" accorded employees, such as health insurance. There is also the obligation of spending time on administrative tasks like billing and negotiating with regulatory agencies, insurance carriers, and physicians, all while making sure to meet all the legal requirements of billing.

For employers, there can be financial advantages to having independent contractor partnerships through savings on payroll taxes and benefits that would be paid to you as an employee. Tread cautiously if you are seeking a position as an employee and are offered an independent contractor role instead, as the IRS may view your position as an employee position rather than as an independent contractor position. In addition, retirement and health benefits are provided only to employees.

The Balanced Budget Act of 1997 (effective January 1998), specifically allows PAs to work as independent contractors under the Medicare program in accordance with the law of the state in which the services are performed.

While checking for the availability of physician-PA team opportunities in your area and before deciding to be an independent contractor, look at the make-up of current employees in the practice you are considering. For example, federally certified rural health clinics must have a PA or nurse practitioner W-2 employee staffing the clinic 50% of the time it is open before hiring additional self-employed PAs.

Be sure to review with your attorney all relevant state and federal laws and regulations that may prohibit your practice as an independent contractor.

The Balanced Budget Act of 1997 (effective January 1998), specifically allows PAs to work as independent contractors under the Medicare program in accordance with the law of the state in which the services are performed, with payments going to the employer. The PA's employer may be a physician, medical group, professional corporation, hospital, nursing facility, or corporation in which PAs have an ownership interest (See section on PA Ownership Interest.).

In the past, CMS ruled that a W-2 employment relationship had to exist for a PA's services to be covered under Medicare. Now, rather than specifically requiring a W-2 employment relationship, Medicare looks for "a valid relationship" to be determined by the Internal Revenue Service (IRS) common-law control test guidelines (Revenue Ruling 87-41, 1987-1 Internal Revenue Cumulative Bulletin 296).

The following points summarize the 20 IRS guidelines used to determine if a worker is an independent contractor. A person (worker) is probably an employee, and not an independent contractor, if:

- The worker is required to comply with another person's instructions about when, where, and how he or she is to perform a job.
- The worker receives training, which indicates that the person for whom the services are performed wants the services performed in a particular way.
- The worker's services are integrated into the business operations to show that the worker is subject to direction and control.
- The worker's services must be rendered personally to indicate that the individual(s) for whom the services are performed are interested in the methods used to accomplish the work as well as the results.
- The individual(s) for whom the services are performed hire, supervise, and pay assistants, indicating control over the workers on the job. If one worker hires, supervises, and pays the other assistants pursuant to a contract under which the worker agrees to provide materials and labor and is responsible only for the attainment of a result, an independent contract status is indicated.
- A continuing relationship exists between the worker and the individual for whom the services are performed. A continuing relationship may exist where work is performed at frequently recurring, although irregular, intervals.
- The individual for whom the services are performed establishes set hours of work.
- The worker works full-time.
- Work is carried out on individual's (employer's) premises.
- The worker follows the order or sequence of the individual for whom the services are performed.
- The worker is required to submit regular or written reports.
- The worker receives payment by the hour, week, or month.
- The worker's travel or business expenses are paid by the employer.
- The worker has significant tools furnished by the employer.
- The worker lacks an investment in the facilities where the business operations occur.
- The worker, generally, cannot realize a loss for providing services.
- The worker does not provide services for a number of unrelated persons or firms at the same time.
- The worker does not make his or her services available to the general public on a regular and consistent basis.
- The employer has the ability to discharge the worker.
- The worker has the right to terminate his or her relationship without incurring liability.

Generally, the IRS states that determining whether an individual is an employee or a contractor "is complex, but is essentially made by examining the right to control how, when, and where the person performs services. It is not based on how the person is paid, how often the person is paid, or whether the person works part-time or full-time. There are three basic areas which determine employment status: behavioral control, financial control, and relationship of the parties."

IRS guidance to employers states: "Generally, a worker who performs services for you is your employee if you have the right to control what will be done and how it will be done. This is so even when you give the employee freedom of action. What matters is that you have the right to control the details of how the services are performed."

The IRS publication, Employer's Supplemental Tax Guide, provides the following: "The general rule is that an individual is an independent contractor if you, the person for whom the services are performed, have the right to control or direct only the result of the work and not the means and

methods of accomplishing the results."

An individual or an employer may ask the IRS to determine whether or not a worker is an employee by filing IRS Form SS-8, Determination of Worker Status for Purposes of Federal Employment Taxes and Income Tax Withholding.

More information about employee and independent contractor distinctions is available on the IRS website.

PA Ownership Interest

The CMS Medicare Carriers Manual instructions allow for employment and practice ownership opportunities for PAs. PAs may own up to 99% of a state-approved corporate entity (e.g., a professional medical corporation, limited liability company, limited liability partnership, etc.) that bills the Medicare program. A sole proprietorship or a general partnership would not be an acceptable ownership structure for PAs who wish to meet Medicare's guidelines. Someone who is not a PA (i.e., a spouse, physician) is able to own the remaining 1% of the corporation, as allowed by state law.

PAs may own up to 99%of a state-approved corporate entity (e.g., a professional medical corporation, limited liability company, limited liability partnership, etc.) that bills the Medicare program.

While there is no specific mention of the 99% ownership limit for PAs in the Medicare manual, this is the percentage CMS agreed to in negotiations with AAPA. Prior to these negotiations, CMS did not allow a PA to have any ownership share of a state-approved corporation.

Medicare law requires that payments be made to the PA's employer. This means that Medicare payments cannot be made directly to a PA under the PA's NPI number or the PA's Social Security number. However, a corporation primarily owned by a PA is an appropriate PA employer that is eligible to receive Medicare reimbursement.

Once formed, the business may be enrolled with Medicare by completing and submitting form 855B. The PA owner must enroll with Medicare by submitting form 855I with respect to his/her business. Bill Medicare with the PA's NPI as rendering provider and the business' NPI and tax ID as billing provider.

Language from Medicare Transmittal #1744, dated March 12, 2002. Section 2156 D reads:

Employment Relationship. Payment for services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/ supplier categories. If the employer of the PA is a professional corporation or other duly qualified legal entity (such as a limited liability company or a limited liability partnership), properly formed, authorized, and licensed under state laws and regulations, that permits PA ownership in such corporation or entity as a stockholder or member, that corporation or entity as the employer may bill for PA services even if a PA is a stockholder or officer of the entity, as long as the entity is entitled to enroll as a "provider of services" or a supplier of services in the Medicare program. PAs may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. Leasing agencies and staffing companies do not qualify under the Medicare program as "providers of services" or suppliers of services. (See §4112 for billing instructions.)

PAs interested in corporate ownership are strongly encouraged to seek the assistance of qualified legal or accounting professionals to ensure compliance with all applicable state and federal requirements.

Note: The PA corporate ownership issue does not affect PAs who own certified rural health clinics (RHCs). For some time, Medicare regulations have allowed PAs to fully own RHCs. That regulation has not changed. For more information, visit the guide's section on RHCs.

Summary Chart: Medicare Policy for PAs

SETTING	SUPERVISOR REQUIREMENT	REIMBURSEMENT RATE	SERVICES
Office/clinic; non-"incident-to" visit	State law	85% of Physician Fee Schedule	All services a PA is legally authorized to provide that would have been covered if provided personally by a physician
Office/clinic; "incident-to" visit	Physician must be in the suite of offices	100% of Physician Fee Schedule[1]	Any service provided to an established patient of the practice and related to an ongoing condition for which a plan of care was established by a physician of the practice
Home visit/house call (not home health services)	State law	85% of Physician Fee Schedule	All services a PA is legally authorized to provide that would have been covered if provided personally by a physician
Home health	State law	85% of Physician Fee Schedule	PAs may provide face-to-face encounter prior to a home health order, but only a physician may order home health and sign the home health plan of care. PAs may provide care plan oversight for home health patients.
Skilled nursing facility	State law	85% of Physician Fee Schedule	Alternated required visits and any additional visits when medically necessary. Physician must perform comprehensive visit.

Hospital; non-shared visit service	State law	85% of Physician Fee Schedule	All services a PA is legally authorized to provide that would have been covered if provided personally by a physician
Hospital; shared visit service	State law	100% of the Physician Fee Schedule	Any E/M service; no procedures, no critical care schedule
First assisting at surgery in all settings	State law	85% of physician first assist fee schedule[2]	All services a PA is legally authorized to provide that would have been covered if provided personally by a physician
Federally certified rural health clinics	State law	Cost-based reimbursement	All services a PA is legally authorized to provide that would have been covered if provided personally by a physician
HMO	State law	Reimbursement is on capitation basis	All services contracted for as part of an HMO contract

1. Using carrier guidelines for "incident-to" services.
2. i.e., 85% x 16% = 13.6% of surgeon's fees.

CARE DELIVERY MODELS

Accountable Care Organizations (ACOs)

Accountable care organizations (ACOs) are networks of healthcare professionals and/or hospitals/health systems that accept financial and medical responsibility for delivering care to a defined patient population. The goal of ACOs is to create financial incentives for healthcare professionals and facilities to encourage them to provide more coordinated, patient-centered care. The expectation is that highly coordinated care will result in improved health outcomes for patients and lower the cost of healthcare.

At present, there are more than 600 government-sponsored and commercial ACOs in operation, from which more than 30 million Americans are receiving their care.

Medicare ACOs that are part of the Medicare Shared Savings Program are required to have a minimum of 5,000 Medicare beneficiaries, with treatment provided by PAs, physicians, and other healthcare professionals. Previous regulations required that patients be treated at least once by a physician to be a considered part of the 5,000 beneficiary threshold. A provision in the 2015 Medicare Physician Fee Schedule (effective January 1, 2015) allows patients who are treated only by a PA to also count toward the 5,000 beneficiary threshold.

To achieve success, ACOs and other integrated delivery systems must coordinate care and share information about patients and treatment plans. Ensuring that care is being delivered at the right time, by the most appropriate healthcare professional, and in the most efficient and effective setting is an essential component to delivering patient-centric, high-quality care.

While most attention has been focused on Medicare ACOs, commercial ACOs are also developing in concert with commercial insurers. In addition, certain states are studying the possibility of establishing ACOs for their Medicaid population.

For a look at how ACOs operate, go here. Additional information on Medicare-sponsored ACOs and the conceptual framework of how care coordination will be enhanced can be found here.

Patient-Centered Medical Homes (PCMHs)

A patient-centered medical home (PCMH) is a healthcare delivery model in which a patient receives coordinated, comprehensive, team-based and quality-focused care delivered by primary care healthcare professionals. A key principle underlying PCMHs is that timely and highly coordinated care that includes patients as partners in the care process can be more cost-effective and produce better health outcomes than the existing and often fragmented style of care delivery.

Official AAPA policy describes a medical home as team-based, coordinated, integrated, patient- and family-centered, culturally appropriate and committed to quality and safety. The policy declares PAs as qualified to serve as a patient's personal provider and to lead medical home teams or practices.

Numerous other organizations and agencies, such as the Joint Commission, the Veterans Administration, and the National Committee for Quality Assurance, have their own definition of PCMHs. Most share similar principles to AAPA's definition and talk in terms of teams of healthcare professionals delivering comprehensive care to patients. Most definitions are provider neutral when discussing which professionals may lead the team.

Many commercial health insurers are establishing PCMHs that deliver care to specific geographic or regional patient populations or for specific types of diseases. Commercial payer policies regarding who may lead medical home healthcare teams can vary from policies put forth in government programs.

Provisions in the ACA on PCMHs

The ACA encourages the use of all types of primary care providers in innovative care models and increases support for primary care. The following are excerpts from the ACA dealing with advanced and innovative primary care health delivery models:

Defining Providers

Title III, Subtitle A, Part III, Encouraging Development of New Patient Care Models

Sec. 3021 establishes a Center for Medicaid and Medicare Innovation within CMS for the development of care models "promoting broad payment and practice reform in primary care, including the patient-centered medical home models." The section specifically promotes models that provide "for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers."

Title V, Subtitle E, Supporting the Existing Health Care Work Force

Sec. 5405 includes PAs in its definition of primary care provider: "The term 'primary care provider' means a clinician who provides integrated, accessible healthcare services and who is accountable for addressing a large majority of personal healthcare needs, including providing preventive and health promotion services for men, women and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a state licensing or regulatory authority, unless otherwise specified in this section."

Independence at Home Demonstrations

The legislative language states:

"Sec 1866D(b)(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

- all the requirements of this section are met;
- the nurse practitioner or physician assistant, as the case may be, is acting consistent with state law; and
- the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role as described in paragraph (1)(A)(i)."

Funding for Primary Care Teams

Regarding funding primary care teams, the relevant sections of the legislation state:

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE …
Subtitle F—Health Care Quality Improvements …
SEC. 3502, COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.
Empowers the HHS Secretary to fund grants or contracts to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to —

Sec 3502 (a) (1) establish health teams to provide support services to primary care providers; and (2) provide capitated payments to primary care providers. Among other things, eligible program must ... b(4) ensure that the health team … includes an "interdisciplinary, interprofessional team of health care providers" that "may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants;"…

Sec 3502 (c) REQUIREMENTS FOR HEALTH TEAMS. — A health team set up through one of these grants or contracts will (2) support patient-centered medical homes, defined as a mode of care that includes: (A) personal physicians or other primary care providers; [As revised by section 10321.] … (C) coordinated and integrated care; … (E) expanded access to care; and Sec 3502 (d) REQUIREMENTS FOR PRIMARY CARE PROVIDERS. — A provider who contracts with a care team shall — (1) provide a care plan to the care team for each patient participant; (2) provide access to participant health records; and (3) meet regularly with the care team to ensure integration of care.

Sec 3502 (f) DEFINITION OF PRIMARY CARE. — In this section, the term "primary care" means the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.

MEDICAID

Overview

Medicaid, authorized by Title XIX of the Social Security Act, and jointly funded by federal and state governments, is a program that pays for medical assistance for low-income individuals, the aged, the disabled, and families with dependent children. Although the federal government sets basic guidelines and pays 50 to 80% of the cost of Medicaid (depending on the state's per capita income), individual states actually administer the program, decide who can provide medical care and reimburse providers for their services.

The Medicaid program, which began on January 1, 1966, provides coverage to individuals who are categorically needy and, at the state's discretion, to individuals and families who are medically needy. Medicaid covers approximately 66 million people, more than 1 out of 5, during at least some portion of a year. The categorically needy Medicaid eligibility groups include people who meet the requirements for Aid to Families with Dependent Children that were in effect on July 16, 1996; its successor, Temporary Assistance for Needy Families; and recipients of Supplemental Security Income (SSI) in most states. The medically needy are people who are otherwise eligible but have not applied for a federal SSI assistance program, or those who have incomes slightly above the income limits set for the categorically needy.

Because Medicaid eligibility has traditionally been based on meeting certain criteria in addition to having a low income, only an estimated 55% to 65% of people who are both without health insurance and living below the poverty level are covered by the Medicaid program. If they choose, states can expand Medicaid coverage to other needy individuals and families who do not meet the categorically or medically needy definitions, either as part of the Affordable Care Act for a federal match (see below), or independently with no matching funds.

To qualify for federal matching funds, state Medicaid programs are required by the federal government to include inpatient and outpatient hospital services, laboratory and x-ray services, and skilled nursing and home healthcare for individuals ages 21 and older. Services such as early periodic screening, diagnosis and treatment (EPSDT) for children, and physician care must also be provided.

PA Coverage

Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, each state can determine whether PAs are eligible providers under its Medicaid program. Currently, all 50 states and the District of Columbia cover medical services provided by PAs in their Medicaid fee-for-service and managed care plans at either the same or a lower rate than that paid to physicians (See Medicaid chart, Appendix W.). Eight states do not cover PAs for first assisting at surgery. In 1981, Congress passed a provision that authorized states to allow PAs and NPs to recertify the need for continued inpatient care for Medicaid beneficiaries in long-term care facilities. Again, each state makes the final decision as to whether it will incorporate that provision into its Medicaid program.

PA Enrollment in Medicaid as Rendering Providers

PAs are able to provide services to Medicaid patients in all 50 states and the District of Columbia and are expected to enroll as, at minimum, "ordering and referring providers." However, in some

states, services provided by PAs are not attributed to PAs because of the requirement to submit claims for services under the collaborating physician. AAPA is working with state chapters and Medicaid agencies in certain states to allow PAs to be enrolled as rendering providers, and thus submit claims identifying their own name and NPI where they are currently restricted. To AAPA, enrollment refers to the ability of PAs to submit claims using their own name and NPI as the rendering provider, rather than under the physician's number. Currently, 43 states and Washington, D.C. authorize enrollment of PAs as rendering providers in their Medicaid program. This number is expected to continue to grow.

The enrollment of PAs as rendering providers does not increase costs for a state's Medicaid program or duplicate services. PAs are currently providing services, but these services are identified under the physician's provider number. When enrolled, payment continues to go to the employer as the "billing provider," with PAs being recognized as the "rendering provider." The benefits of PA enrollment, such as increased transparency and accountability, aid both the Medicaid program as well as patients.

PAs should check with the provider enrollment or provider relations department of their state Medicaid office to determine the registration process (if any) and the billing procedures. Contact information for each state's Medicaid office may be found in Appendix X of this guide.

Trends

Because of healthcare costs, states are finding it difficult to pay for their Medicaid programs. Medicaid expenditures are the fastest growing part of many states' budgets.

To respond to these cost pressures, states are increasingly looking at ways to slow the rate of growth in their Medicaid programs. Some of the methods currently being used to achieve that goal include freezing enrollment, reducing available services, tightening eligibility rules to decrease the number of citizens that qualify for various Medicaid programs, reducing payments to healthcare professionals, and increasing the required cost-sharing payments from Medicaid beneficiaries.

The federal government requires that states adhere to basic guidelines under the Medicaid program. Therefore, to experiment with innovative methods of delivering and financing medical care, states must obtain specific authority from CMS in the form of a Medicaid waiver. Two such waiver categories are known as 1115 and 1915 waivers, which are exemptions to Sections 1115 and 1915 of the Social Security Act.

Section 1115 waivers, known as research and demonstration waivers, allow states to test (for a five-year period) new approaches to providing care for Medicaid enrollees. States are using such waivers to design their own eligibility rules, extend coverage to uninsured residents, and convert their entire Medicaid program into a managed care plan.

Section 1915 waivers, known as program waivers, permit more limited Medicaid modifications. Section 1915 waivers may be used to provide at-home or community-based services for Medicaid enrollees who would otherwise have to be institutionalized. Section 1915B waivers are also used to rescind Medicaid's freedom-of-choice requirement and allow states to mandate that their Medicaid enrollees receive care from managed care plans.

States generally seek 1115 and 1915 waivers to implement programs that will generate savings by replacing fee-for-service medicine with a managed care/capitated reimbursement plan. However, there may be potential problems for PAs regarding the Medicaid waiver process.

For example, some states that are integrating managed care concepts into their Medicaid programs have required that enrollees be assigned to a primary care provider (PCP). The PCP is permitted to enroll a fixed number of patients, typically ranging from 1,500 to 2,500 patients per provider. Since PAs are not automatically considered PCPs, state Medicaid programs may fail to recognize PAs as PCPs and neglect to allocate additional patients to the practice. One county limited the number of patients "assigned" to a PA to 1,000. After a local PA explained the negative effect of this policy, the county made changes in its program and allowed PAs to treat the same number of patients that physicians were allowed to treat.

The Balanced Budget Act of 1997 (BBA 1997) contained language beneficial to PAs under Medicaid. A provision in the BBA 1997 gives states the ability to name PAs as primary care case managers under their Medicaid programs. The BBA 1997 also gave states greater flexibility in using managed care options to provide healthcare to its Medicaid population without having to apply for official waivers.

The Affordable Care Act and Medicaid Coverage

The Affordable Care Act (ACA) expanded Medicaid coverage. Due to the ACA, federal funding has been made available to states to increase Medicaid coverage to cover adults, 65 and younger, with incomes up to 138% of the federal poverty level without coverage categories that existed previously. Children 18 and younger are eligible in families with incomes up to 138%of the federal poverty level in all states. While traditionally the government has not provided matching funds to those states that expanded their coverage, from 2014 to 2016 there was 100% federal funding for newly eligible adults with Medicaid health insurance. Federal funding gradually decreases to 90% in 2020 and subsequent years.

States have the option to expand Medicaid. The following is the current (as of January 2018) status of Medicaid expansion by state (including the District of Columbia):

EXPANDING MEDICAID (33)	NOT EXPANDING MEDICAID (18)
Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia	Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming

In states that are expanding Medicaid, qualifying individuals and families may enroll in Medicaid without cost. In states where Medicaid is not expanding, the income threshold for Medicaid eligibility is at 100% of the federal poverty level. Medicaid and the Children's Health Insurance Program (CHIP) may be applied for year-round, unlike exchange/marketplace plans that may be procured only during open enrollment periods.

More information can be found on the healthcare.gov website.

CMS Electronic Health Record (EHR) Incentive Programs

The Electronic Health Record (EHR) Incentive Programs provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they implement, upgrade, or demonstrate meaningful use of certified EHR technology. The Medicare and Medicaid incentive programs are designed to support healthcare professionals and certain facilities in their adoption and utilization of health information technology to improve the quality, safety, and efficacy of patient care activities.

The HITECH Act authorizes a Health Information Technology Extension Program to support and serve healthcare providers to help them quickly become adept and meaningful users of EHRs. Regional Extension Centers (RECs), designed to make sure that primary care clinicians get the help they need to use EHRs, focus their most intensive technical assistance on clinicians (physicians, PAs, and NPs) furnishing primary care services, with a particular emphasis on individual and small group practices (fewer than 10 clinicians with prescriptive privileges). Clinicians in such practices deliver the majority of primary care services, but have the lowest rates of adoption of EHR systems and the least access to resources to help them implement, use, and maintain such systems. RECs will also focus intensive technical assistance on clinicians providing primary care in public and critical access hospitals, community health centers, and in other settings that predominantly serve uninsured, underinsured, and medically underserved population.

Eligible Professionals

Under the Medicaid program, PAs are eligible in PA-led RHCs and Federally Qualified Health Centers (FQHCs). Physicians are eligible under both the Medicare and Medicaid programs. Nurse practitioners and nurse midwives are eligible under the Medicaid program.

Medicaid EHR Incentive

PAs are eligible for the Medicaid EHR incentive when working at an FQHC or RHC that is "so led" by a PA. CMS has clarified "so led" to mean:

- When a PA is the primary provider in a clinic. For example, an RHC with a part-time physician and a full-time PA would be considered "PA-led."
- When a PA is a clinical or medical director at a clinical site of practice.
- When a PA is an owner of an RHC.

Additionally, for the Medicaid incentive, there is a percentage volume requirement. Eligible professionals must have a minimum of 30% of their visits with Medicaid patients as unique encounters. Pediatricians may have 20%.

Note: You can no longer apply for participation in the Medicaid EHR incentive program. The Medicaid EHR incentive payments expire in 2021.

MEDICARE EHR INCENTIVE PROGRAM	MEDICAID EHR INCENTIVE PROGRAM
Run by CMS (only physicians are eligible)	Run by your state Medicaid agency
Maximum incentive amount is $44,000	Maximum incentive amount is $63,750
Payment over five consecutive years	Payments over six years; does not have to be consecutive
Payment adjustments began in 2015 for providers who are eligible but decided not to participate.	No payment adjustments for providers who are only eligible for the Medicaid program
Payment adjustments began in 2015 for providers who are eligible but decided not to participate.	In the first year, providers receive an incentive payment for adopting, implementing or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.

Chart courtesy of CMS

Disclaimer: This summary is provided for informational purposes only and does not constitute legal or payment advice. The ultimate responsibility for statutory and regulatory compliance, as well as the proper submission of claims, rests entirely upon the provider of services.

Meaningful Use

The Medicare and Medicaid EHR Incentive Programs provide a financial incentive for the "meaningful use" of certified EHR technology to achieve health and efficiency goals. By putting into action and meaningfully using an EHR system, providers will reap benefits beyond financial incentives such as reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation. PAs may document meaningful use even though they are not eligible, except in very limited circumstances, for the EHR incentive payment.

Note: In 2017, the Medicare EHR Incentive Program was replaced by the Advancing Care Information category under MIPS (See section on the Quality Payment Program.).

COMMERCIAL HEALTH INSURANCE COMPANIES

Overview

Compared to public insurance providers, such as Medicare and Medicaid, commercial health insurance companies present a different challenge for coverage of medical services provided by PAs. Although nearly every insurer covers medical and surgical services delivered by PAs, there are a large number of insurance companies, HMOs, and PPOs in the marketplace. Policies may differ both in how services provided by PAs are covered and in how claim forms should be submitted. Even within the same insurance company, PA coverage policies can change based on the particular plan that an individual or group has selected, the specific type of service being provided, and the part of the country in which the service is delivered.

It is important to understand the role commercial insurance companies play in the claims and reimbursement process. Commercial insurance companies are in business to make a profit, not unlike General Motors or IBM. In fact, one of the major goals of even nonprofit insurers is to increase their cash reserves (the equivalent of profit to a nonprofit company).

An insurance company is required to live up to its legal and contractual obligations as stated in its policy document, which is to provide an agreed-upon service for a given price (premium). Insurers are not necessarily in business to ensure that everyone receives access to care. Nor are they in business to guarantee that all qualified healthcare providers are fairly and adequately compensated for their services. There is often an attempt to try to assign "moral obligations" to insurance companies, but they are not obligated to accept them. Although the hope and expectation are that insurance companies have a basic concern about the health needs of the population they serve, fair payments to practitioners may not be their primary consideration.

Provisions in the ACA have set a minimum standard for the types of benefits that all plans must offer and prohibit the exclusion of healthcare professionals as a class. This means that an insurer could not exclude PAs or other professionals "across the board" from delivering care in a health plan.

Some insurers are attempting to reduce the number of healthcare professionals that are included as eligible providers in their respective plans. This is a concept known as forming a "narrow network." You can read more about "narrow networks" in an article from PA Professional.

Coverage for PA-Provided Services

Generally, insurance plans state that they cover medically necessary services provided by PAs. Some plans use broad terminology when referring to the types of healthcare practitioners that may provide services under the plan. Other insurance companies utilize the concept of PAs delivering "physician" services. Insurers use this logic when dealing with claims for medical services provided by a PA if those services are billed under the physician's name. Some insurer policies require that the bill for medical services provided by PAs be filed under the physician's name and provider number. Other commercial insurers want the claim to be filed under the PA's name. PAs should check with the individual insurance company (normally the claims department or the provider/professional relations department) for their particular policy on coverage for medical and surgical services provided by PAs.

Four Major Commercial Insurers

Although there are many commercial insurance companies, the chart below highlights four major insurers and their reimbursement policies regarding PAs. It is important to note that this information is based on responses to AAPA questions from national representatives of Aetna, Anthem, Cigna, and United Healthcare in 2016. PA policy may still vary depending on different factors such as practice type or location. The chart breaks down whether PAs submit claims using their own NPI, whether they are recognized as primary care providers (PCPs) by the insurer, and whether PAs are included in their provider directories. For more information about provider directories, see the Recognition of Services Provided by PAs section of this book.

Among these four insurers, PA coverage policy is nuanced depending on the commercial insurance provider and can differ depending on the state where a PA practices. These variances emphasize the importance of a PA fully understanding the reimbursement policy of each insurer that they encounter in their practice.

Aetna, *18 million members*

- PAs may submit claims using own NPI number
- State policy determines whether a PA can be recognized as a PCP
- PAs and NPs are included in provider directories

Anthem, *33 million members*

- PAs in Colo., Conn., Ga., Ind., Ky., Mo., Nev., N.Y., Ohio, and Wis. may submit claims using own NPI number. PAs in Calif., Maine, N.H., and Va. must submit claims under a physician's NPI number.
- State policy determines whether a PA can be recognized as a PCP.
- State policy determines whether PAs are included in provider directories.

Cigna, *11.4 million members*

- Generally, credentialed PAs may submit claims using own NPI number.
- State policy determines whether a PA can be recognized as a PCP.
- Credentialed PAs and NPs are included in provider directories.

United Health, *70 million members*

* PAs may submit claims using own NPI number.
* If the supervising physician is a PCP, the PA is also considered a PCP.
* PAs are included in provider directories.

Contacting Commercial Payers

When contacting insurance companies to determine their policies on coverage for medical services provided by PAs, be sure to phrase your questions using terminology that the company understands. Do not ask someone in the insurance company's claims or provider relations department if PAs are "reimbursed for services provided under the company's health plan." Because many companies do not directly reimburse PAs, the person on the phone may say they are not.

However, if you ask whether medical and surgical services performed by a PA are covered, you will usually find that the services are reimbursable. The two ways of asking that question may seem to be just a matter of semantics, but to an insurer, there may be a fundamental difference.

When you contact an insurance carrier, be sure to document the name and contact information of the plan representative who provides the information. You should also ask for references and/or copies of pertinent policy manual citations for your files.

Sample Questions

Here are some sample questions you should ask when trying to clarify a company's policies:

Coverage/Recognition

When the PA in our practice treats patients, how should the claim be submitted?
(If the payer's answer is "no," be sure to ask if it is appropriate to bill for PA services under the physician's number/group tax ID.)

Credentialing/Enrollment

Are PAs credentialed by your plan? Are PAs enrolled in your plan? What is the process for credentialing and/or enrollment?
Is it the same process/form as for physicians?
Do you use CAQH as a credentialing mechanism?

Provider Numbers

Is the PA's NPI number used?

Billing/Claims Submission Instructions

How should PA services be billed?
Should we bill under the PA's name/NPI/plan provider number, under the physician's name/NPI/plan provider number, or under the PA's name and group tax ID number?

Ask for specific instructions for completing claims on the 1500 form for services provided by PAs. For example: What information, if any, goes into Box 24 J? Box 33? Whose signature, if any, is required?

Reimbursement Rate

What is the reimbursement rate for services provided by PAs? (The rate is usually expressed as a percentage of the contracted physician rate/fee schedule.)

Collaboration/Supervision

Do you defer to state law to define PA/physician collaboration?

Scope of Practice/Covered Services

Does your plan defer to state law to define PA scope of practice?
Are there any limitations to covered services provided by PAs? (Some plans do not allow coverage for consultations, critical care services, behavioral health services, assisting at surgery, etc.)

Assisting at Surgery

Are PAs covered for first assisting at surgery by your plan? Does your plan have an approved procedures or exclusion list? What modifier should be used for PAs first assisting at surgery? What is the reimbursement rate for PAs first assisting at surgery, as a percentage of the primary surgeon's fee? Does your plan require prior authorization for a PA first assistant at surgery? May claims for assisting at surgery (performed by the PA) be submitted on the same claim as the surgeon's claim for the surgery, or must they be separate?

Provider Directories

Are PAs listed by name in any provider directories made available to patients? May they be listed as primary care providers?

Hospital Setting

Are PAs covered when providing services in the hospital setting? Is state law used to guide the services PAs deliver?
If a PA is hospital-employed, but the collaborating/supervising physician is not, how are the PA's professional services covered by your plan? (Example: PA's NPI in Box 24J, hospital tax ID in Box 33).

Plan Types

Does your organization have both fee-for-service plans and managed care plans? Medicare Advantage Plan? Are the policies for each plan the same in regard to PA services?

Does the managed care plan have a patient panel size for a physician practice? If yes, what is the panel size?
If a PA joins the practice, does the panel size for the practice increase? If yes, by how many?

Special Policy Considerations – "Incident-to"

Does this plan recognize/allow for "incident-to" billing? What are the conditions that apply? (Does this plan recognize "incident-to" consistent with Medicare policy?)

Note: "Incident-to" billing is a Medicare provision with specific rules and conditions that, when all elements are met, allows for a service provided by a PA to be billed under the physician's NPI with reimbursement at the full physician rate. Plans that enroll PAs may also recognize "incident-to" billing.

This is not the same as plans who choose not to enroll PAs, where claims are submitted under the physician's NPI. Unless specifically stated, do not assume that "incident-to" rules apply in order to submit claims for PAs. In most cases, no on-site physician is required, nor is the physician required to see the patient on the initial visit, unless specifically stated in policy.

Miscellaneous

Are the policies of your plan pertaining to nurse practitioners (NPs) different from those pertaining to PAs? If yes, how specifically?

Do they bill under their own provider numbers? What is their reimbursement rate?

Handling Claim Denials From Commercial Insurers

What should you do if a claim is denied? Do not forget about it, and do not consider it uncollectible. It is important for you and your practice to contest any and all unfair denials.

Before deciding that you have been treated unfairly by a third-party payer, make sure that you ascertain the reason given for the denial. Most commercial insurance companies and government payers will send a written reason for the denial, often known as the explanation of benefits (EOB).

First, check the EOB or the denial notice to eliminate the possibility of a simple error, such as an incorrect CPT code, a missing provider signature or other clerical error that caused the denial. The EOB should specifically indicate if the denial was because a PA provided the service (often stated as "service only covered when provided by an MD/DO" or "PAs not considered authorized providers under the plan").

Denials for First Assisting

The two most common reasons a first-assisting-at-surgery claim is denied are use of the incorrect modifier and use of an assistant on a restricted code. While Medicare uniformly uses the AS modifier for first assisting at surgery, commercial insurance companies determine which modifier they use, typically AS, 80, 81 or 82. Do not assume that all companies use the same modifier. Like Medicare, most insurance companies have a specific list of surgical codes for which a first assistant at surgery is not covered.

When you receive a denial, contact the insurance company and verify that the correct modifier was used. Also verify that the surgical procedure billed allows for a first assistant. If the insurance company does not have a surgical list and uses "medical necessity" as coverage criteria, then you must back up your decision to use the assistant.

To do this, check the Medicare lists (Appendices L1, L2, L3). Coverage by Medicare can lend support that use of an assistant is medically necessary. Next, look to the American College of Surgeons (ACS). The ACS, along with 15 other surgical subspecialty organizations, publishes a report that, in their opinion, suggests when a surgical procedure requires a physician as an assistant at surgery. While this study references the need of a physician as an assistant at surgery, it can be generalized to address the overall need for a first assistant, including a PA. The latest survey was

published in 2016, using all the surgery codes in the AMA's 2016 CPT manual. You may also wish to include any medical research references that would support your appeal.

Ready to Fight, but With Whom?

Before you develop a plan of action, find out who has the ability to reverse the claim denial. If an individual directly purchased the insurance policy, you may safely assume that the insurance company alone made the decision about whether your services were covered. However, do not make that same assumption for a patient who has group health insurance coverage through an employer.

In that case, receiving an EOB or letter of denial from an insurance company (even if it is on the insurance company's letterhead) does not necessarily mean that the insurance company is the ultimate decision maker in this situation. The insurance company might simply be the third-party administrator of the health insurance plan and another entity — the company for whom the patient works — may actually make decisions concerning the practitioners covered under the health plan. Make sure that your efforts are directed at the decision maker and not the "messenger."

If you're seeking help with an appeal from AAPA, or any outside party, please do not send EOBs or other documents if patient names and identifiers are visible. While information about what services were denied and why they were denied is helpful, disclosing patient names and identifiers is a HIPAA privacy rule violation. Either effectively block out patient names and identifiers before sending or complete and submit AAPA's claim denial form.

State PA Reimbursement Mandates

Overview

A number of states have statutory reimbursement language, often known as a reimbursement mandate, that requires commercial third-party payers to reimburse for services delivered by PAs. Some PA reimbursement mandates are specific to a particular type of service, such as first assisting at surgery, while other mandates cover all covered, medically necessary services provided by PAs.

Such mandates typically do not apply to government programs such as Medicare and Medicaid. In addition, those commercial health insurance plans that are self-insured, typically larger companies that fund their employee health plans, are not subject to state reimbursement mandates.

States may also have other coverage mandates that are not PA specific, but cover healthcare professionals more broadly.

See the chart below for a list of states with PA mandates and citations to language that appears in state law.

Number	State	Citation	Coverage Mandate Language
1.	**Alabama**	Ala. Code §27-51-1	Payment to physician for medically necessary services provided by a PA.
2.	Alaska	**Alaska Stat. Sec. 21.36.090**	Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, physician assistant, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, licensed professional counselor, or certified direct-entry midwife.

3.	Arkansas	**23-79-154**	(b) A health plan shall not refuse to reimburse a physician at the full rate for health care services provided by a physician assistant if the practice complies with the laws of this state. (c) A health plan shall not impose a practice or supervision restriction on a physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of this state.
4.	**Connecticut**	CT Gen. Stat. Sec. 38a-526	Policy after 10/1/1994 shall provide coverage of PAs. Provisions that apply to similar services by other licensed providers apply to services provided by PAs.
5.	**Delaware**	Cite; Title 18 Insurance code; 1300 Health Insurance General Provisions 1312 Standards of payment for Assisting at Surgery (formerly Regulation 83)	First assisting at surgery
6.	**Florida**	FL Stat. Ann Sec. 458.347(5)	Must pay a PA first assistant if coverage would have been provided for a physician.
7.	**Illinois**	225 ILCS 95/5.5	Payment to employer if the payer would have made payment to a licensed physician.
8.	**Iowa**	House file 2144, section 1. 514C.11	Payment for services provided by a PA within scope of practice if payment would be made to a physician.
9.	**Kentucky**	304.17A-1473	First assisting at surgery
10.	**Michigan**	MI Comp. Laws Sec. 550.1401d	(a) If the services were performed by a physician's (sic) assistant working for a physician or facility specializing in a particular area of medicine, a physician that specializes in that area of medicine was physically present on the premises when the physician's assistant performed the services. (b) If the services were performed by a physician's assistant working for a physician or facility engaging in general family practice, a physician need not have been physically present on the premises when the physician's assistant performed the services so long as a consulting physician is within 150 miles or 3 hours' commute to where the services are performed.

11.	**Montana**	MT Code Ann. Sec 37-20-405	Physician or institution may bill for services provided by PAs.
	Montana	MT Code Ann. Sec 33-22-111	Insurance companies must provide freedom to choose licensed practitioner.
	Montana	MT Code Ann. Sec 33-22-114	An insurer, etc. shall provide coverage for services provided by a PA as normally covered contracts for services provided by the physician if services a PA provides are covered by contract.
12.	**North Carolina**	N.C. Gen. Stat. Sec. 58-50-26	No denial of payment because a PA rendered service under rules of board.
	North Carolina	N.C. Gen. Stat. Sec. 58-50-30	If policy provides for payment for service within PA's scope of practice, insured or other person are entitled to payment.
13.	**Oregon**	743A.036	Services provided by certified nurse practitioner or licensed physician assistant: Whenever any policy of health insurance provides for reimbursement for a primary care or mental health service provided by a licensed physician, the insured under the policy is entitled to reimbursement for such service if provided by a licensed physician assistant or a certified nurse practitioner if the service is within the lawful scope of practice of the physician assistant or nurse practitioner…(4) An insurer may not reduce the reimbursement paid to a licensed physician in order to comply with this section.
14.	**Texas**	TX Rev. Civ. Stat. Ann Sec. 21.25, Sec. 1	Payers may not discriminate in payment for services provided by a PA if the same services are covered when performed by other practitioner of healing arts.

WORKERS' COMPENSATION

Overview

Workers' compensation (also known as industrial insurance) is a type of program that provides insurance coverage for employees who are injured on the job. Workers' compensation also has provisions dealing with the payment of benefits to dependents of employees killed in the course of, or as a result of, their employment.

These programs are administered by each state. The rules regulating those practitioners who may provide medical treatment, assess a worker's medical condition, and certify a return to work status are also determined by individual states. In some states, more than one insurer participates in the state workers' compensation program. On rare occasions, policies affecting PAs in a particular state can vary by insurer.

Check with your state for more specific information. Contact information for workers' compensation offices throughout the country may be found in Appendix Y. In addition to asking about a PA's ability to treat workers' compensation patients, you should also inquire whether PAs can treat the patient on the first visit and sign the certification of disability and return to work form(s).

At this time, PAs are not authorized to diagnose and treat federal employees who are injured on the job. AAPA has been working through Congress to change the Federal Employees Compensation Act to allow PAs to treat federal workers injured on the job.

For more information, see the chart below (information collected in 2015) that details AAPA's survey results of each state workers' compensation program.

State Workers' Compensation Programs

STATE	PA COVERED PROVIDER	REIMBURSEMENT RATE (% physician fee)
ALABAMA	Yes	100%
ALASKA	Yes	85%
ARIZONA	Yes	85%
ARKANSAS	Yes	90%
CALIFORNIA	Yes	85%
COLORADO	Yes	100%
CONNECTICUT	Yes	70% of the fee schedule for the procedure code

STATE	PA COVERED PROVIDER	REIMBURSEMENT RATE (% physician fee)
DELAWARE	Yes	100% if physician is on-site; 80% if not on site
DISTRICT of COLUMBIA	Yes	100%
FLORIDA	Yes	85%
GEORGIA	Yes	Yes
HAWAII	Yes	85%
IDAHO	Yes	100%
ILLINOIS	Yes	100%
INDIANA	Policy of individual companies	Policy of individual companies
IOWA	Policy of individual companies	Policy of individual companies
KANSAS	Yes	85%
KENTUCKY	Yes	80%
LOUISIANA	Yes	Policy of individual insurance companies
MAINE	Yes	100%
MARYLAND	Yes	100%
MASSACHUSETTS	Yes	85%
MICHIGAN	Yes	85%
MINNESOTA	Yes	100%
MISSISSIPPI	Yes	85%
MISSOURI	Policy of individual companies	Policy of individual companies
MONTANA	Yes	100%
NEBRASKA	Yes	100%
NEVADA	Yes	85%

STATE	PA COVERED PROVIDER	REIMBURSEMENT RATE (% physician fee)
NEW HAMPSHIRE	Policy of individual companies	Policy of individual companies
NEW JERSEY	Policy of individual companies	Policy determined by individual insurance companies
NEW MEXICO	Yes	100%
NEW YORK	Yes	100% or 75% in HPSA
NORTH CAROLINA	Yes	100%
NORTH DAKOTA	Yes	100%
OHIO	Yes	85%
OKLAHOMA	Yes	85% or by contract
OREGON	Yes	85%
PENNSYLVANIA	Yes	85%
RHODE ISLAND	Yes	80%
SOUTH CAROLINA	Yes	85%
SOUTH DAKOTA	Yes	100%
TENNESSEE	Yes	85% of Medicare fee schedule
TEXAS	Yes	85%
UTAH	Yes	75%
VERMONT	Yes	100%
VIRGINIA	Policy of individual companies	Policy of individual companies
WASHINGTON	Yes	90%
WEST VIRGINIA	Yes	Rates set by individual companies
WISCONSIN	Yes	No set fee schedule, generally paid at physician rate
WYOMING	Yes	100%

TRICARE

Overview

Established in 1998, TRICARE (formerly known as CHAMPUS), is a program that provides healthcare for active duty dependents, military retirees and their dependents, and survivors of deceased military personnel who are unable to use government or military medical facilities because of overcrowding, distance from the facility, or unavailability of appropriate medical treatment. Approximately 9.4 million people receive medical care under the TRICARE program.

PA Coverage

TRICARE covers all medically necessary services with the possible exception of psychiatric services provided by a PA. The PA and the physician with whom the PA works must both be authorized TRICARE providers and must provide care according to state law. The employer or employing physician bills, indicating the PA as the rendering provider, and is reimbursed for services provided by the PA.

Outpatient opioid use disorder treatment with FDA-approved products, prescribed and monitored by PAs and other professionals, is covered by TRICARE. A valid PA/NP waiver, issued under the Controlled Substances Act, amended by the Drug Addiction Treatment Act of 2000, and verified through the Substance Abuse and Mental Health Services Administration (SAMHSA), may be required. If required, PAs and other qualified professionals must register with the DEA to dispense controlled substances and must be in possession of an assigned DEA special identification number.

Coverage under TRICARE for all medical services provided by PAs, including assisting at surgery, is at 85% of the TRICARE Fee Schedule. There are certain procedures (CPT codes) for which TRICARE will not reimburse for a surgical first assistant. This first-assistant-at-surgery restriction applies to both PAs and physicians.

TRICARE uses a discounted fee-for-service payment schedule; however, it is not the same fee schedule used by Medicare. Both the fee schedule and the list of codes for which TRICARE will not pay for anyone to first assist may be obtained by contacting your local TRICARE claims processor or by writing to the Office of Civilian Health and Medical Program of the Uniformed Services/TRICARE, Aurora, CO 80045-6900.

TRICARE uses the basic CMS 1500 claim form for submitting claims (the UB-92 form for institutional settings), and PAs are required to use the 80, 81, or 82 modifier code when they first assist at surgery. No modifier code is used for medical services provided by PAs in the office or clinic setting.

TRICARE does not use the "incident-to" billing procedure for medical services provided by PAs. TRICARE Policy Manual Sections 6010.58-M indicates medical services provided by PAs are to be billed "as a separately identified line item (e.g., PA office visit) and accompanied by the assigned PA provider number." In addition, there are certain instances in home, office, or hospital care when a PA and physician can perform components of a procedure, other than assistant-at-surgery, and bill the combined service with the physician's NPI. In these instances, the allowable charge billed under the physician, "may not exceed the allowable charge for the procedure rendered by a physician."

RURAL HEALTH CLINICS

Overview

In 1977, Congress passed the Rural Health Clinic (RHC) Services Act (Public Law 95-210) to increase the availability of primary care services to rural communities that had a shortage of physicians and other healthcare professionals. The RHC Services Act addressed the provider shortage problem by extending Medicare and Medicaid payment to PAs, NPs, and CNMs who staff certified RHCs.

RHCs can be public, private, or nonprofit. A major advantage of RHC status is enhanced reimbursement rates for providing services in rural, underserved areas. RHCs must have a PA, NP, or CNM staffing the clinic a minimum of 50% of the time the clinic is operating.

Services

For purposes of Medicare and Medicaid coverage, RHC services include medical services and those services and supplies furnished as "incident-to" professional covered services. In areas where there is a shortage of home healthcare agencies, the services of a visiting nurse on a part-time or intermittent basis to homebound patients would be a covered service.

Staffing

The RHC must employ at least one PA, NP, or CNM to staff the clinic a minimum of 50% of the time the clinic is operating. The RHC does not need to have a physician on site. Federal regulations used to require a physician to be on site at least once every two weeks, but now only require collaboration/supervision consistent with state law. If state law is more restrictive than federal Medicare policy, then the state law prevails.

Payment Policy

RHCs can be either provider-based (clinics that are owned and operated by a hospital, skilled nursing facility, or home health agency) or independent (typically owned by a physician, PA, or NP).

RHCs are typically paid cost-based compensation, based on an all-inclusive rate per visit (as opposed to the fee-for-service payment method used for medical services provided by PAs under Medicare or Medicaid in non-RHC practice settings). The rate per visit is determined by totaling the clinic's reasonably incurred costs for providing care and dividing that figure by the total number of patient visits. A visit is defined as a face-to-face encounter with a PA, MD, DO, NP, CNM, CP, or CSW. Reasonable costs include rent or the cost of leasing space from an entity/individual that does not own the clinic, utilities, supplies and equipment, and salaries for medical providers and clerical support.

For independent RHCs, there is a maximum amount or cap on the rate per visit that will be paid. The cap is adjusted each year based on the Medicare Economic Index. The calendar year 2017 payment limit was $82.30. Provider-based RHCs with more than 50 beds have the same cap. Provider-based RHCs with fewer than 50 beds do not have a cap. The RHC payment limit per visit for calendar year 2018 is $83.45, a 1.4% increase.

Because costs and the number of Medicare patients treated may vary each year, the rate-per-visit cost can change and must be estimated at the beginning of the year. If the actual numbers are different from the estimate (which is likely), then Medicare will make an adjustment, up or down, to reflect the actual rate-per-visit figure at the end of the year. Because of this adjustment, some suggest (especially in the clinic's first year of operation) that 10% of the clinic's revenues be held in a separate "reserve" account in case the actual number of patients treated is higher than expected or actual costs are lower than expected and money has to be paid back to Medicare.

State Medicaid programs are required to reimburse RHCs. However, in 2000 Congress changed the method by which Medicaid paid RHCs from a cost-based system to a prospective payment system (PPS). States also gained the ability to develop an alternative payment methodology, but each RHC in the state must individually agree to accept the state-developed alternative methodology.

PA RHC Ownership

PAs are eligible to have 100% ownership of RHCs. Reimbursement is paid to the clinic. This is a separate issue from PA ownership under the Medicare program, which allows a PA to own up to 99% of a state-approved corporation.

Over the years, certain services, such as hospital services and laboratory tests, have been "carved out" of the RHC payment methodology and are only billable to Medicare Part B. That has created a dilemma for PA RHC owners as the Medicare program had a policy of not issuing Part B billing numbers to businesses owned solely by a PA. With no means to bill the services to Medicare Part B, the PA-owned RHC had to take a loss when providing services.

A PA in Texas, Gayle Pugh, fought and overturned a CMS ruling that prohibited a PA who was sole owner of an RHC from obtaining a Medicare Part B billing number. On October 17, 2014, an administrative law judge issued a ruling stating that a PA-owned RHC was a legitimate employer of a PA and was eligible to obtain a Part B billing number (Decision Number CR3420 and Docket Number C-14-1317 (See Appendix Z.).

Additional RHC Resources

Here are some additional resources that provide information on RHCs.

Starting a Rural Health Clinic — A How-To Manual

RHC Rules and Guidelines

FAQ on RHC Issues

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Overview

Begun in 1960, the Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored health plan in the United States. The FEHB program, which consists of a wide array of health plan options administered by the Office of Personnel Management (OPM), provides health insurance coverage for approximately 8.2 million federal employees, retirees, and dependents. Enrollees have more than 300 plans from which to choose. Enrollment in the FEHB program is voluntary; however, approximately 85% of federal employees and 90% of retirees who are eligible participated in FEHB plans in 2014.

Generally, PAs are covered healthcare professionals within the FEHB program. However, the FEHB program includes fee-for-service, preferred provider organization (PPO), and health maintenance organization (HMO) health plans. Certain PPO and HMO plans may have restrictions as to which healthcare professionals may treat their enrollees.

FEHB program premiums vary based upon the particular plan selected and are paid by the employer (federal government agency) and the employee. The employer pays an amount up to 72% of the average plan premium (not to exceed 75% of the actual premium) and the employee pays the rest.

Each year, there is an open enrollment period during which federal employees and retirees have an opportunity to change health plans within the FEHB program.

Coverage in Underserved States

In past years, the FEHB plan designated certain states as underserved, which mandated that all licensed healthcare professionals in those states be covered for plan services they provided to eligible FEHB plan beneficiaries. Due to healthcare practitioner anti-discrimination language in the Affordable Care Act affecting all qualified health plans, there is no longer a need for the FEHB plan provider mandate or a listing of underserved states.

Selected Large FEHB Plans and Coverage Policies for PAs

COMPANY	PA IN OFFICE OR CLINIC?	RESTRICTION?	HOSPITAL?	PA FIRST ASSIST?	BILL UNDER PHYSICIAN?
Health Alliance (not Alliance)	Yes	None, state law for scope of practice	Yes	Yes, in-network PAs must be contracted to first assist	PA submits application to be in-network; bills with own NPI as rendering provider.
Foreign Service Benefit Plan	Yes	None, state law for scope of practice	Yes	Yes	Uses Aetna's Choice POS2 network; bill with PA's NPI as rendering provider
GEHA	Yes	None, state law for scope of practice	Yes	Yes	Bill with tax ID as rendering and billing provider. Uses many networks.
Mail Handlers	Yes	None, state law for scope of practice	Yes	Yes	Uses Aetna's Choice POS2 network; bill with PA's NPI as rendering provider
NALC	Yes	None, state law for scope of practice	Yes	Yes	Uses Cigna's network, bill like billing Cigna under physician or PA per contract
Rural Carrier Benefit Plan	Yes	None, state law for scope of practice	Yes	Yes	Uses Aetna's Choice POS2 network; bill with PA's NPI as rendering provider

SELF-INSURED HEALTH PLANS

Overview

Most large and many medium-sized businesses are choosing to self-insure their employee group health insurance plans. When a business self-insures, it assumes the financial risk of paying the health costs of covered employees. These self-insured businesses may contract with traditional insurance companies to handle the plan's administration, paperwork, and claims processing. In this situation, the insurance company becomes the third-party administrator or provides administrative services only.

The decision as to which medical practitioners will be considered covered providers under the plan is made by the business, which often receives guidance and actuarial input from the insurance company. A call to the insurance company whose name is on the EOB/denial letter can uncover whether the health plan is one of the following:

- An indemnity-type plan, in which covered provider decisions are made by the insurance company
- A self-insured plan, in which the patient's employer controls who will be considered a covered or authorized provider

Businesses tend to self-insure for at least two reasons. First, they can save money by eliminating the:

- Insurer's profit margin required to keep a reserve pool of money used to pay claims.
- Insurer's cost for actuarial duties related to calculating premiums.
- Tax imposed by certain states on health insurance premiums.

Second, the legal and regulatory burdens are reduced when a business self-insures its employee health plan. Instead of being regulated by the insurance requirements in each state where the business has employees, self-insured plans fall under the jurisdiction of the federal Employee Retirement Income Security Act of 1974 (ERISA), which typically has compliance requirements that are much less demanding than state requirements.

What should you do if a claim is denied because a service is provided by a PA? If the plan is self-insured, deal with the health benefits department of the business that employs your patient. Explain the situation to the patient and ask if he or she would be willing to help resolve the matter. Tell the patient that you have provided quality medical care and it is only fair that your services be covered. Most of your patients will be willing to help. A letter written by both the practice and the patient to his or her health benefits office will often be sufficient to reverse the denial.

In a situation where the patient's health plan is not self-insured and the insurance company makes the final decision on covered practitioners, you will need to direct your concerns to what motivates insurers to change their coverage policies.

Keep in mind what is important to insurance companies: retaining quality business or subscribers as customers, maintaining or increasing their market share, and maintaining a positive corporate image. Channeling your efforts toward these issues will give you a better chance of getting paid for your services.

Your response to a claim denial needs to be multifaceted. It is important to enlist the support of the patient and/or the business that pays the premium to the insurer. Their unhappiness or dissatisfaction has a direct impact on each of the three areas mentioned above that are of greatest concern to the insurer.

If you get a denial due to the fact that the services were performed by a PA, contact AAPA's Third-Party Reimbursement Office at 571-319-4349.

TELEMEDICINE

Overview

Telemedicine is the use of real-time communication equipment, such as webcams, to link healthcare professionals with patients in different locations. It improves healthcare cost efficiency by reducing transportation costs, increasing rural patients' access to specialists, and facilitating better communication between healthcare professionals in different regions.

Telemedicine and Medicare

Pursuant to Medicare Transmittal #1885, dated May 16, 2003, Medicare law allows PAs, physicians and certain other healthcare professionals to be reimbursed for providing telemedicine services to patients.

Medicare covers telehealth services, such as consultations (including emergency department and initial inpatient consultations), office visits, individual psychotherapy and pharmacologic management. Follow-up inpatient consultations may also be provided to beneficiaries in hospitals and SNFs (HCPCS codes G0406-G0408). Covered telehealth services are added each year in CMS' Physician Fee Schedule Final Rule.

Individuals living in rural HPSAs and counties not classified as metropolitan statistical areas are eligible for these reimbursements, as are patients of healthcare entities participating in federal telemedicine demonstration projects. Providers at the distant site submit claims for telemedicine services using the appropriate CPT code or Healthcare Common Procedure Coding System (HCPCS) code. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements. The CQ modifier is used on professional claims when providers are participating in the federal telemedicine demonstration programs.

For more information, see Appendix F.

Modifiers

GQ modifier – Providers participating in the federal telemedicine demonstration programs in Alaska or Hawaii must submit the appropriate CPT or HCPCS code for the professional service along with the modifier GQ, "via asynchronous telecommunications system."

GT modifier changes – The GT modifier, (via interactive audio and video telecommunications systems), was a procedure code indicating that the distant site provider certified the beneficiary was present at an eligible originating site when the service was furnished. Change Request 10152, dated November 29, 2017, eliminated the requirement to use the GT modifier on professional claims for telehealth services. Now, use of the place of service or POS Code 02 certifies that the service meets the telehealth requirements.

*Note that for distant site services billed under critical access hospital (CAH) method II on institutional claims the GT modifier will still be required.

Commercial payers may have their own coverage policies and modifiers for telehealth services.

The Public Health Institute has a telemedicine resource that contains information about reimbursement for telemedicine services that may be useful.

Electronic Health Records

Overview

The electronic health record (EHR) is a digital medical record designed to provide more coordinated care for individuals and better health for populations. When appropriately designed and implemented, the value of EHRs has been demonstrated to improve quality, increase patient safety, improve operational efficiencies, provide cost savings, and improve patient experience and satisfaction

Electronic Health Records and Medicare

The Health Information Technology for Economic and Clinical Health (HITECH Act) enacted under the American Recovery and Reinvestment Act of 2009 provided funding to improve the nation's healthcare by promoting the meaningful use of electronic health records (EHR) via incentives. Although PAs were not included as eligible providers (EPs) for incentive payments under the previous Medicare EHR Incentive Programs, also known as "meaningful use," PAs were recognized as EPs under the Quality Payment Program (QPP).

Under the Merit-based Incentive Payment System of the QPP, PAs and other EPs may earn a payment adjustment based on one of four categories, one of which is advancing care information (ACI). By using certified EHR technology (CEHRT), PAs earn points toward the ACI component of MIPS and may earn a positive payment adjustment under the QPP.

If participating in the QPP under the Advanced Alternative Payment Models (Advanced APMs) option, use of CEHRT is required. EPs who receive a percentage of payments through qualifying Advanced APMs will be exempt from MIPS adjustments and eligible for other incentives.

Electronic Health Records and Healthcare

Because of the importance of EHRs in healthcare delivery and reimbursement, AAPA developed the EHR Toolkit to help PAs advocate for EHR systems that are designed, selected, and implemented with functionality considerations for PAs. Four key issues were identified as critical for EHRs to be fully functional and operational for PAs, and all healthcare professionals:

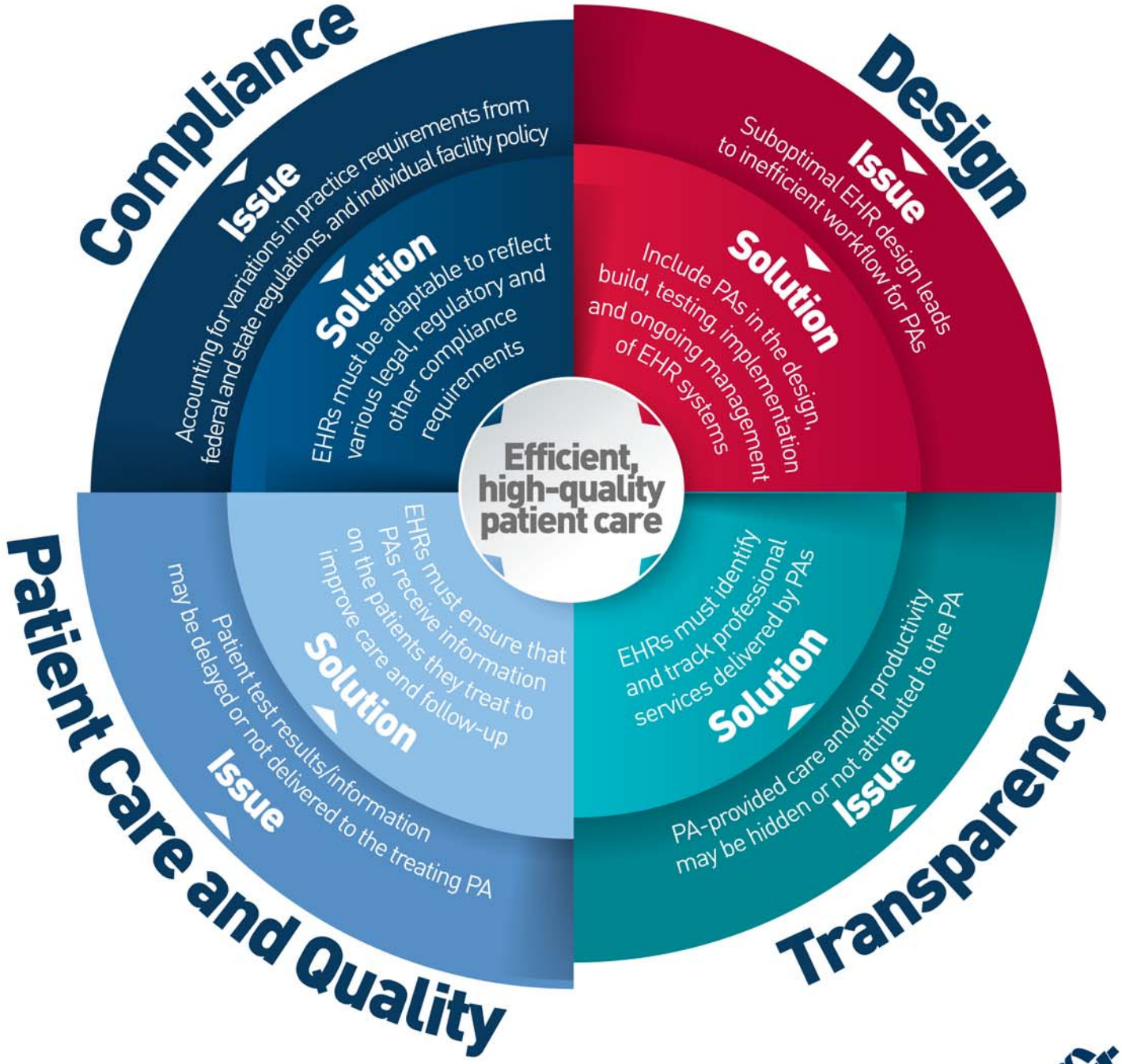
- Design
- Transparency
- Compliance
- Patient Care and Quality

For more information, see Appendices AA1, AA2, AA3, AA4.

Optimizing EHR Systems

Electronic health record (EHR) systems must be fully functional and operational for all healthcare professionals, including PAs.

Four Keys to Success



Contact **Sondra DePalma** at **sdepalma@aapa.org** for more information.

AAPA

THE AFFORDABLE CARE ACT

Overview

In March 2010, the Affordable Care Act (ACA) was signed into law. Provisions of the law were intended to expand coverage options, to increase access to services, to ensure that more money was being spent directly on care, and to reduce costs. Some specific provisions include:

- Establishment of Health Insurance Marketplaces/exchanges to provide individuals and small businesses a method to compare and enroll in commercial coverage options. PAs are covered healthcare professionals in all state marketplaces. These marketplaces also let beneficiaries know about financial assistance they may qualify for or if they are instead eligible for Medicaid.
- Expansion of Medicaid (in all states that agree) to cover individuals with incomes up to 138% of the federal poverty level at an increased contribution from the federal government.
- Allowing young adults up to age 26 to stay on a parent's plan.
- Prohibition against insurance companies denying coverage or charging someone more due to a pre-existing condition.
- Elimination of annual or lifetime limits on insurance benefits.
- The right to appeal denied access to services.
- Coverage of many preventive services at no cost to beneficiaries.
- The condition that insurance companies must now spend 80% (for small group and individual market insurers) and 85% (for large group market insurers) of what they receive from enrollee premiums on care provision and quality improvement.
- Efforts to curb waste, fraud, and abuse in federal programs.
- The requirement on most individuals to have health coverage or otherwise face a tax penalty (repealed by Congress in December 2017).
- The closure of the Medicare "donut hole" by 2020.
- The creation of new entities, such as the Patient-Centered Outcomes Research Institute and the Center for Medicare and Medicaid Innovation that seek to increase comparative effectiveness research and test alternative payment models, respectively.

The ACA and PAs

A number of these provisions, or their intended effects, directly influence and possibly benefit the PA profession. Some of the ways in which the ACA affects PAs are as follows:

- As a result of numerous provisions designed to expand health insurance coverage, millions more Americans are now insured. Consequently, in the coming years, the healthcare system will likely rely more on PAs.
- The ACA recognizes PAs as an essential part of the solution to the primary care shortage by formally acknowledging them as one of the three primary care health providers. The ACA also commits to expanding the number of PAs by providing financial support for scholarships and loan forgiveness programs, as well as by funding the training of 600 new PAs.
- Another provision of the ACA that has affected PAs is the development of new payment models, such as accountable care organizations and patient-centered medical homes, which focus heavily on coordination of care. PAs will play a large part in this coordination, as the health workforce continues to adopt an increasingly team-oriented approach to care provision.

Selected Major Provisions of the ACA

Guaranteed Issue

Before January 1, 2014, insurance companies were able to deny coverage for individuals based on pre-existing health conditions, to keep costs down. Because of the ACA, health insurers will no longer be able to deny access to insurance coverage as a result of current or prior health conditions. This applies to all individual and small group health insurance policies.

Health Insurance Marketplaces

Active as of fall 2013, these marketplaces (also known as exchanges) are websites, available through www.healthcare.gov, at which individuals and small businesses can compare and contrast commercial health plan options, learn what and how much financial assistance they may be eligible for, and determine whether they are eligible for Medicaid (individuals).

Financial assistance is available through advanced tax credits that lower the monthly premium for those with incomes between 100% and 400% of the federal poverty level, as well as cost-sharing assistance for those with incomes between 133% and 250% of the federal poverty level.

Essential Health Benefits

Health insurance plans in the individual and small group market (whether inside or outside of the health insurance marketplaces) are required to offer services in 10 basic coverage categories deemed the essential health benefits (EHBs). These EHBs will vary by state, as each plan in a state is required to have their basic services similar to a designated state "benchmark plan." Plans are able to deviate from the benchmark plan in the specific services offered, as long as they do not change the actuarial value of services offered within that category.

The 10 EHB benefit categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

Medicaid Expansion

States have the option of whether or not to expand their Medicaid programs by increasing the income threshold to 138% of the federal poverty level and eliminating some restrictions on eligibility. Before expansion, states varied significantly in their Medicaid eligibility ranges and most did not cover childless adults. In states that choose to expand, the federal government paid 100% of the cost at first, and slowly reduces it to 90%. Currently, 33 states and the District of Columbia have expanded or have indicated they will expand their Medicaid programs.

The Individual Mandate

Most individuals (those who do not qualify for an exemption) were initially required to possess adequate health insurance or otherwise pay a penalty. This was intended to reduce uncompensated care and expand insurance plan risk pools to reduce coverage price. Congress repealed the individual mandate in December 2017.

RECOGNITION OF SERVICES PROVIDED BY PAs

Overview

Coding and documentation are essential to recording patient care and treatment information and to submitting claims to insurers and payers. Yet, many healthcare professionals do not receive sufficient instruction on this important subject during their medical training.

Proper chronological documentation of a patient's history and all relevant facts allows all healthcare professionals reviewing the medical record to appropriately design care plans, simplify utilization reviews and enhance communication and coordination. Documentation can also help ensure that standards and procedures were followed as required for reimbursement purposes. Certain guidelines are required for evaluation and management (E/M) service documentation, such as inclusion of diagnosis, plan of care, medical history, risk factors, and patient progress.

CMS provides additional information on the Medicare Documentation 1995 and 1997 Guidelines for E/M Services.

Currently, a substantial percentage of medical services delivered by PAs to Medicare, Medicaid, and commercial patients are "hidden" in the healthcare system. That is, due to certain payer-authorized billing provisions and/or the fact that some payers do not enroll/credential PAs, some PA-provided medical services are billed under the name of the physician or medical group with whom the PA works. When this occurs, the ability to track the services PAs deliver to patients is lost.

Due to this lack of recognition, it is difficult, if not impossible, to appropriately measure the volume of services or the quality of care delivered by PAs. When PA-provided services aren't tracked, the impact of PAs within state and federal healthcare programs is lost. In addition, accurate data collection and appropriate analysis dealing with workforce issues are absent.

CMS has encouraged full accountability and transparency for the services provided by healthcare professionals (recognition of ordering and referring providers) in the Medicare and Medicaid programs. Yet, due to certain Medicare billing rules, such as the "incident-to" provision, it is estimated that 40% to 60% of PA-provided care in the private office setting, for example, is not billed under the PA's name.

State and federal officials and policymakers may be unable to determine if network adequacy standards are being met for primary care or specialty care as they can't tell who and how many healthcare professionals are providing care in a given community or geographic area. Network adequacy refers to the ability of a public or commercial health insurance plan to make available an appropriate number of both primary and specialty healthcare professionals to ensure that patients have reasonable access to covered health services.

Looking forward to the transition to value-based reimbursement, PAs (and advanced practice nurses) run the risk of being excluded from participation in the CMS movement toward programs such as the Merit-based Incentive Payment System (MIPS) due to this lack of recognition. As CMS consolidates the Physician Quality Reporting System, meaningful use requirements, and other quality metrics into MIPS, healthcare professionals will be rated against their peers on performance

and quality metrics. If services provided by PAs and others are not adequately tracked or accounted for due to the lack of claims data, these healthcare professionals could potentially be faced with exclusion from MIPS, Physician Compare, and other CMS programs due to the program's low-volume threshold provision. (See the Quality Payment Program section for more details on the low-volume threshold.) Patients being treated by these professionals might not be able to determine the quality scores of their healthcare provider. Tens of thousands of healthcare professionals could potentially be left out from full participation in the CMS fee-for-value programs that represent the cornerstone for improving care outcomes and reducing healthcare costs.

Accurate PA recognition will in no way change state or federal laws regarding the range of services PAs are authorized to perform, and there is no increase in the amount of reimbursement paid to PAs. For improved accuracy and accountability, AAPA encourages all payers to enroll/credential PAs, list PAs in provider directories, and have policies requiring that claims be submitted under the name of the healthcare professional who performed the service.

Tracking PA Productivity

As the U.S. healthcare system transitions from a fee-for-service payment system to a value-based reimbursement framework, and practices and healthcare systems brace for lower reimbursements, the desire to both demonstrate and better quantify the productivity of PAs, physicians, and other healthcare professionals has increased. Accurately comparing productivity among various healthcare professionals, however, is a challenge due to the inability to consistently define what productivity means and the often inadequate data that is available to make those comparisons.

Other measures focusing on quality of care, treatment outcomes, patient satisfaction, and resource utilization will also have an impact on productivity, value, and reimbursement.

Understanding productivity and the reimbursement revenue cycle can provide greater insight into more efficient utilization and staffing models, assist in maximizing legitimate reimbursement for the practice, or help to determine compensation packages.

There are myriad factors that must be considered when one attempts to determine PA productivity or compare it to that of other PAs or physicians. Those factors include the issue of utilization, or how PAs are authorized to practice. If PAs are authorized to practice to the full extent of their education and expertise, their ability to be highly productive is enhanced. Does the PA have access to an adequate number of patients? Another important consideration is how many of the services provided by the PA are in fact billed under the name of the physician. If the full range of medical and surgical services is not appropriately tracked, then it is virtually impossible to determine a PA's true level of productivity or contribution to the practice.

Keep in mind that productivity is not just measured by reimbursement. It includes the other services that must be delivered by a professional authorized to practice medicine, whether they are separately billable or billed under the physician. Also, when a PA, instead of the physician, provides the non-billable postoperative global visit, it frees the physician/surgeon to perform a billable office visit or procedure, which increases the overall revenue flow to the practice.

Typical non-billable activities that should be factored into assessments of a PA's productivity include postoperative care that is part of the global surgical package, answering emails and telephone calls, prescription refills, mentoring or teaching other healthcare professionals, and consultations with other healthcare professionals.

A more detailed explanation on measuring PA productivity can be found in two articles located in Appendix AB.

Provider Directories

Provider directories are listings maintained by public and commercial insurers and third-party payers that alert beneficiaries to the healthcare professionals within their insurance network. The information in a provider directory varies from insurer to insurer, but may include information regarding provider specialty, location, contact information, certification, languages spoken, and whether they are accepting new patients, among other information. As a result of the Affordable Care Act, more Americans have health insurance and are in the process of selecting both plans and providers. It is vital that the information beneficiaries receive about their network of providers is timely and accurate so they can determine the best coverage and care options for them. Information on care availability is particularly important in rural or underserved areas, and for plans with limited networks.

While not always the case, PAs and NPs are occasionally omitted from an insurer's directory. However, as critical members of healthcare teams, PAs and NPs should both be included. Many states have laws and rules requiring health plans to maintain current or comprehensive provider directories. However, these laws and policies vary widely from state to state and may contain general or vague language relating to the types of providers that must be listed. For example, California passed a law, effective January 2017, that specifically requires all health plans to have listings of the following contracted providers: "physicians, surgeons, nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers…, nurse midwives, and dentists." Other states may have laws or policies with ambiguous language requiring the inclusion of "all providers." Most concerning is that some state laws contain physician-centric language that could be interpreted as enabling insurers to exclude healthcare professionals such as PAs. It's important to confirm PA inclusion in the provider directory of each insurer or health plan with which you interact.

APPENDIX A
MEDICARE PAYMENT AT 85%

Appendix A

PROGRAM MEMORANDUM INTERMEDIARIES/CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. AB-98-15

Date APRIL 1998

Change Request #202

SUBJECT: Increased Medicare Payment and Billing Requirements for Nurse Practitioners (NPs), Physician Assistants (PAs) and Clinical Nurse Specialists (CNSs)--Balanced Budget Act (BBA) of 1997.

The Law Prior to the Passage of the BBA of 1997

Prior to January 1, 1998, the law allowed physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) to be paid for services of the type that are considered physicians' services. PAs performed their services under the supervision of a physician in a hospital, skilled nursing facility (SNF), nursing facility (NF), or as an assistant at surgery in both rural and urban areas. PAs also furnished and were paid for services under the supervision of a physician in physicians' offices and patients' homes in rural areas that are designated under §322 (a)(1)(A) of the Public Health Service Act as health professional shortage areas (HPSA). In addition, payment could be made for services of both NPs and CNSs furnished in collaboration with a physician in all settings in a rural area. Medicare also made payment for services of NPs in SNFs and NFs in an urban area.

Payment for PA, NP, and CNS Services

Prior to January 1, 1998, payment for PA services was allowed to be made only to the actual employer of the PA at 85 percent* of the physician fee schedule (excluding services inherent to assistant at surgery.) Payment for the services of a PA or NP performing as an assistant at surgery was made at 65 percent of the physician fee schedule. The employer of a PA might have been a physician, medical group, professional corporation, hospital, SNF, or NF.

Prior to January 1, 1998, payment for NP or CNS services, when furnished in all settings in a rural area, could have been made either directly to the NP or CNS, or to the employer or contractor of the NP or CNS at 75 percent of the physician fee schedule for services furnished in a hospital and at 85 percent of the physician fee schedule for services furnished in other settings. However, payment for NP services when furnished in SNFs and NFs in an urban area was to be made to the employer of the NP at 85 percent of the physician fee schedule. For this purpose, the employer of a NP or CNS could have been a hospital, rural primary care hospital, SNF, NF, physician, group practice, or ambulatory surgical center (ASC) with which the NP or CNS has an employment or contractual relationship.

**AAPA Note: Medical services delivered in hospitals were covered at 75 percent of the physician fee schedule.*

Balanced Budget Act of 1997

Provisions

Effective January 1, 1998, §4511 and §4512 of the BBA of 1997 remove the restrictions on the type of areas and settings in which the professional services of NPs, CNSs, and PAs are paid for by Medicare. Accordingly, payments are allowed for services furnished by these non-physician practitioners in all areas and settings permitted under applicable state licensure laws, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such professional services. We note that ordering and referral services are included in the payment for services performed. No separate payment is made for ordering or referring services. This provision also expands the professional services benefits for NPs and CNSs by authorizing them to bill the program directly for their services when furnished in any area or setting. However, the provision maintains the current policy that no separate payment may be made to one of these non-physician practitioners when a facility or other provider payment or charge is also made for such professional services. A facility or other provider includes a hospital, SNF, NF, comprehensive outpatient rehabilitation facility (CORF), ASC, community mental health center (CMHC), rural health center (RHC), or federally qualified health center (FQHC).

Payment for NP, PA, and CNS Services

In most cases, separate payment is allowed for NP, PA, and CNS services provided in a facility setting. For example, in the case of NP, PA, and CNS professional services furnished to patients in a partial hospitalization program provided by a CMHC or a hospital outpatient department, such services are separately covered and paid. These professional services are unbundled from the partial hospitalization benefit, and NPs and CNSs must bill the Part B carrier directly for such services when provided to partial hospitalization patients. However, PA professional services furnished to partial hospitalization patients can be billed to the carrier only by a PA's employer.

Separate payment for the professional services of NPs, PAs, and CNSs provided in a rural health clinic RHC or a FQHC setting is not permitted. The professional services of NPs, PAs, and CNSs are bundled with other facility services when furnished to patients under the RHC and FQHC benefits. The payment made to the RHC or FQHC under the all-inclusive rate specifically accounts for the services of these non-physician practitioners furnished in the RHC or FQHC setting because the facility payment rate reflects the costs for these services.

Carriers should be alert that certain professional services furnished by NPs, CNSs and PAs on or after January 1, 1998, within the scope of their state license in RHCs and FQHCs are included in the payment to the facility. Examples of services payable under the facility payment include: visit codes, surgeries, interpretations of diagnostic tests, and services and supplies incident to their professional services such as injectable drugs.

In those situations where carriers are denying the service because the payment to the facility covers the charges submitted to the carrier, use EOMB message 17.18 (Payment for these services are made under Part A of Medicare). The provider must submit this bill to the Part A intermediary or MSN 17.9. (Medicare Part A/Part B pays for this service.) The provider must bill the correct Medicare contractor. Use remittance advice: Claim adjust denial code 97 (Payment is included in the allowance for the basic service/procedure) with new line level remark code M97 (Not paid to practitioner when provided in this place of service. Payment included in the reimbursement issued the facility.)

Increased Payment

The BBA of 1997 increases the payment for PAs, NPs, and CNSs to 80 percent of the lesser of either the actual charge of 85 percent of the physician fee schedule amount. For assistant at surgery services, payment equals 80 percent of the lesser of either the actual charge or 85 percent of the physician fee schedule amount paid to a physician serving as an assistant at surgery.

HCFA-Pub. 60AB

Billing Requirements for PA Services

Payment for PA services is made only to the PA's employer, regardless of whether the PA is employed as a W-2 employee or whether the PA is a 1099 employee, who is acting as an independent contractor. Accordingly, while a PA has an option in terms of selecting employment arrangements, only the "employer" (W-2 or 1099 as the case may be) can bill a carrier or intermediary for the PA's services.

When PAs are ordering or referring service(s), these providers must submit their name and the surrogate Unique Physician Identification Number (UPIN) "NPP000" in block 17 and 17a of Form HCFA-1500. For National Standard Format (NSF) claims, submit UPIN "NPPOOO" in record/field FB1-09.0 as the ordering provider of this service. Providers submitting ANSI claims must submit the surrogate UPIN "NPP000" in X12N 837 field: 2-500.E-NM109.

When PAs are rendering service(s), form HCFA-1500 must contain the Provider Identification Number (PIN) of the PA after "PIN#) in item 33. Item 33 must also contain the employer's name, address, etc. where payment is to be directed.

If the employer is a group practice, they must include their group PIN number in item 33 after "GRP PIN#," including the name, address, etc. where payment is to be directed, and list the individual PA's PIN number in item 24k.

For NSF claims, providers must submit the individual PA's PIN in field NSF FAO 23.0 of the electronic claim record. Providers submitting ANSI claims must submit the individual PA's PIN in X12N 837 (2-500.B-NM109 (mp,zz). The group PIN will be reported in NSF BA0-09 and ANSI X2N 837 in 2-003-PRV03.

Billing Requirements for NP and CNS Services

In order to prevent duplicate billings and/or payments, we are requiring NPs and CNSs to submit claims to the Part B carrier under their own respective billing number for their professional services furnished in facility or other provider settings except in the case where the services of these non-physician practitioners are clearly facility services and are specifically included in the costs that are covered by the intermediary payment to the facility. Only the facility may bill and be paid for non-physician practitioner services where the services are billable as facility services and are bundled or included in the facility payment.

When NPs and CNSs are ordering or referring services, these providers must submit their name and the surrogate UPIN "NPP000" in block 17 and 17a of the paper claim form. For NSF claims, submit UPIN "NPP000" in record/field FB1-09.0 as the ordering provider of this service. Providers submitting ANSI claims must submit the surrogate UPIN "NPP000" in X12N 837 field: 2-500.E-NM109.

When NPs and CNSs are rendering service(s), the carrier assigned PIN on the NP or CNS should be entered after "PIN#" in item 33 of Form HCFA-1500, including the name, address, etc. where payment should be directed. Providers submitting NSF claims will enter the PIN in NSF record FAO-23.0. For ANSI X12 837 claims, the PIN number is entered in 2-500B-NM109.

For NPs or CNSs who are members of a physician group practice, the PIN of the performing non-physician practitioner must be entered in item 24k of Form HCFA-1500. The group practice must enter their group practice PIN after "GRP PIN" in item 33. They must also include the name, address, etc. where payment should be directed.

For NSF claims, submit the PIN in field NSF FAO 23.0 of the electronic claim record. Providers submitting ANSI claims submit the PIN in 2-500.B-NM109 (mp,zz). The group practice PIN will be reported in NSF BA0-09 and for ANSI X12N 837 claims in 2-003-PRV03. When services of several different members within a physician group practice are billed on the same HCFA-1500 claim form, the PIN of the performing non-physician practitioner is entered in the corresponding line item.

Qualifications for CNSs

The BBA of 1997 also includes a clarification concerning the qualifications for CNSs. The BBA requires that a CNS must be a registered nurse who is licensed by the State in which he or she practices, and she or he must hold a master's degree in a defined clinical area of nursing from an accredited educational institution.

"Incident to" Services Not Affected by These Provisions

Services provided "incident to" physicians' services and payable under §1861(s)(2)(A), by the carrier, are not affected by §§4511 and 4512 of the Balanced Budget Act. "Incident to" services must still be provided by employees of the physician under the physician's direct supervision. Also, those services continue to be paid for under the physician fee schedule as though physicians personally performed them. This means that payment for those services is based on 100 percent of the physician fee schedule amount. Such "incident to" services may be provided by PAs, NPs, CNSs, nurses, medical assistants, technicians, etc., who are employed by physicians.

HCFA is considering future policy changes that would pay for services furnished "incident to" physicians' professional services at the Medicare rate applicable to other recognized non-physician practitioners who have independent practitioner benefits under the program, such as PAs, NPs, and CNSs. In the meantime, current payment rules for "incident to" services which base payment at 100 percent of the physician fee schedule for such non-physician practitioners, as well as any other "incident to" staff, remain in effect.

Also unchanged is the fact that services provided "incident to" physicians' services to hospital patients (inpatients or outpatients) continue to be payable only to the hospital through the hospital benefit. Payment for those services is bundled into our payment for hospital outpatient or inpatient services. Therefore, no separate Medicare carrier payment is made to physicians for those services. "Incident to" services in a hospital performed by PAs, NPs and CNSs are only payable to the hospital, by intermediaries, as part of the hospital outpatient or inpatient payment. (See §2050 of the Medicare Carriers Manual.)

Issuance of Practitioner Billing Numbers

For NPs and CNSs who have not previously billed the Medicare program, the carrier will need to issue PINs for direct billing purposes. PINs for PAs must be issued for claim line item identification purposes only and should not be recognized for direct billing/payment purposes. If a billing or identification PIN has not been issued prior to January 1, 1998, any legally performed non-physician practitioner services furnished on or after January 1, 1998 may be back billed and paid once a billing number is assigned, provided the claims are timely filed. In order to minimize the impact on new practitioners, applications for billing/identification numbers from CNSs and NPs received during the first quarter of calendar year 1998 should be processed on a priority basis in the most expeditious manner possible. All NPs, CNSs, and PAs must have their own PIN to bill Medicare, even if they are employed and even if their employer has always billed for their services using the employer's PIN with a modifier. Payment for NPs, CNSs, and PAs will be based on PINs and not on modifiers except for assistant at surgery claims in which case a modifier is necessary.

Provider Notification

Include information on the BBA of 1997 changes that affect PAs, NPS, and CNSs in your next regularly scheduled provider bulletin.

These instructions should be implemented within your current operating budget.

This Program Memorandum may be discarded after January 1, 1999.

Contractors should contact the appropriate regional office with any questions. Regional office staff may direct operational questions to Joan Proctor-Young on (410) 786-0949. Policy questions can be directed to Roberta Epps on (410) 786-4503, Terri Harris on (410) 786-6830 or Regina Walker-Wren on (410) 786-9160.

HCFA-Pub. 60AB

APPENDIX B
MEDICARE QUALIFICATIONS FOR PAS

190 - Physician Assistant (PA) Services

(Rev. 1, 10-01-03)

B3-2156

Effective for services rendered on or after January 1, 1998, any individual who is participating under the Medicare program as a physician assistant for the first time may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish PA services in the State where the services are performed. PAs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the PA benefit.

See the Medicare Claims Processing Manual, Chapter 12, "Physician and Nonphysician Practitioners," §110, for payment methodology for PA services. Payment is made under assignment only.

A. Qualifications for PAs

To furnish covered PA services, the PA must meet the conditions as follows:

1. Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or
2. Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
3. Be licensed by the State to practice as a physician assistant.

B. Covered Services

Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General

The services of a PA may be covered under Part B, if all of the following requirements are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets all the PA qualifications,
- They are performed under the general supervision of an MD/DO;
- The PA is legally authorized to perform the services in the state in which they are performed; and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.

2. Incident To

If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in §60.

3. Types of PA Services That May Be Covered

State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. Carriers should consider developing lists of covered services. Also, if authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.

Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

See §60.2 for coverage of services performed by PAs incident to the services of physicians.

4. Services Otherwise Excluded From Coverage

The PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these

services are precluded from coverage even though they may be within a PA's scope of practice under State law.

C. Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.

D. Employment Relationship

Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories. If the employer of the PA is a professional corporation or other duly qualified legal entity (such as a limited liability company or a limited liability partnership), properly formed, authorized and licensed under State laws and regulations, that permits PA ownership in such corporation nor entity as a stockholder or member, that corporation or entity as the employer may bill for PA services even if a PA is a stockholder or officer of the entity, as long as the entity is entitled to enroll as a "provider of services" or a supplier of services in the Medicare program. Physician Assistants may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. Leasing agencies and staffing companies do not qualify under the Medicare program as "providers of services" or suppliers of services.

APPENDIX C
MEDICARE AUTHORIZATIONS INCLUDING HOSPITAL H&PS AND FRACTURE CARE

DEPARTMENT OF HEALTH HUMAN SERVICES Health Care Financing Administration
Director
Center for Health Plans and Providers

Excerpt from letter dated April 25, 2000

Mr. William Kohlhepp, President
American Academy of Physicians Assistants
950 North Washington Street
Alexandria, Virginia 22314-1552

Dear Mr. Kohlhepp:

Thank you for your letter regarding the implementation of the Balanced Budget Act of 1997 (BBA) provision concerning physician assistant (PA) services. I regret the delay in this response.

Section 4512 of the BBA amended section 1861(s)(2)(K)(i) of the Social Security Act (the Act) to permit PAs to perform services under the supervision of a physician in states where the PAs are legally authorized to perform such services. I would like to address each of your concerns in turn.

High Level Evaluation and Management Services, Initial Hospital History and Physical, Consultations. Mental Health Services and Patients with Fractures

The Health Care Financing Administration (HCFA) has not established a policy that would prohibit the PAs from providing these services. If a PA is authorized by state law to provide such services, the PA may perform this service and the PA's employer may bill the local Medicare carrier for medically necessary services.

Durable Medical Equipment (DME)

Nothing in the Act prohibits a PA from authorizing the Certificate of Medical Necessity for DME. Therefore, if a PA is authorized by state law to provide such services, the PA may perform this service and the PA's employer may bill the local Medicare carrier for medically necessary services.

Outpatient Physical Therapy

HCFA published a final rule on November 2, 1998, in the Federal Register that permits PAs to order the rehabilitation treatment plan. Specifically, 42 CFR 410.61(b) allows a PA to establish the treatment plan.

I hope this information is helpful.

Sincerely,

Robert A. Berenson M.D.

Robert A. Berenson, M.D.
Director
Center for Health Plans and Providers

APPENDIX D
MEDICARE AUTHORIZATIONS FOR FLEXIBLE SIGMOIDOSCOPIES AND FECAL OCCULT BLOOD

Title 42: Public Health
PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS
Subpart B—Medical and Other Health Services

§410.37 Colorectal cancer screening tests: Conditions for and limitations on coverage.

(a) Definitions. As used in this section, the following definitions apply:

(1) *Colorectal cancer screening tests means* any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(i) Screening fecal-occult blood tests.

(ii) Screening flexible sigmoidoscopies.

(iii) Screening colonoscopies.

(iv) Screening barium enemas.

(v) Other tests or procedures established by a national coverage determination, and modifications to tests under this paragraph, with such frequency and payment limits as CMS determines appropriate, in consultation with appropriate organizations

(2) *Screening fecal-occult blood test* means—

(i) A guaiac-based test for peroxidase activity, testing two samples from each of three consecutive stools, or,

(ii) Other tests as determined by the Secretary through a national coverage determination.

(3) An *individual at high risk for colorectal cancer* means an individual with—

(i) A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;

(ii) A family history of familial adenomatous polyposis;

(iii) A family history of hereditary nonpolyposis colorectal cancer;

(iv) A personal history of adenomatous polyps; or

(v) A personal history of colorectal cancer; or

(vi) Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

(4) *Screening barium enema means*—

(i) A screening double contrast barium enema of the entire colorectum (including a physician's interpretation of the results of the procedure); or

(ii) In the case of an individual whose attending physician decides that he or she cannot tolerate a screening double contrast barium enema, a screening single contrast barium enema of the entire colorectum (including a physician's interpretation of the results of the procedure).

(5) An *attending physician for purposes of this provision* is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

(b) *Condition for coverage of screening fecal-occult blood tests.* Medicare Part B pays for a screening fecal-occult blood test if it is ordered in writing by the beneficiary's attending physician, physician assistant, nurse practitioner, or clinical nurse specialist.

(c) *Limitations on coverage of screening fecal-occult blood tests.* (1) Payment may not be made for a screening fecal-occult blood test performed for an individual under age 50.

(2) For an individual 50 years of age or over, payment may be made for a screening fecal-occult blood test performed after at least 11 months have passed following the month in which the last screening fecal-occult blood test was performed.

(d) *Condition for coverage of flexible sigmoidoscopy screening.* Medicare Part B pays for a flexible sigmoidoscopy screening service if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act), or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and §§410.74, 410.75, and 410.76) who is authorized under State law to perform the examination.

(e) *Limitations on coverage of screening flexible sigmoidoscopies.* (1) Payment may not be made for a screening flexible sigmoidoscopy performed for an individual under age 50.

(2) For an individual 50 years of age or over, except as described in paragraph (e)(3) of this section, payment may be made for screening flexible sigmoidoscopy after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(3) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening colonoscopy performed, payment may be made for a screening flexible sigmoidosocopy only after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

(f) *Condition for coverage of screening colonoscopies.* Medicare Part B pays for a screening colonoscopy if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(g) *Limitations on coverage of screening colonoscopies.* (1) Effective for services furnished on or after July 1, 2001, except as described in paragraph (g)(3) of this section, payment may be made for a screening colonoscopy performed for an individual who is not at high risk for colorectal cancer as

described in paragraph (a)(3) of this section, after at least 119 months have passed following the month in which the last screening colonoscopy was performed.

(2) Payment may be made for a screening colonoscopy performed for an individual who is at high risk for colorectal cancer as described in paragraph (a)(3) of this section, after at least 23 months have passed following the month in which the last screening colonoscopy was performed, or, as provided in paragraphs (h) and (i) of this section, the last screening barium enema was performed.

(3) In the case of an individual who is not at high risk for colorectal cancer as described in paragraph (a)(3) of this section but who has had a screening flexible sigmoidoscopy performed, payment may be made for a screening colonoscopy only after at least 47 months have passed following the month in which the last screening flexible sigmoidoscopy was performed.

(h) *Conditions for coverage of screening barium enemas.* Medicare Part B pays for a screening barium enema if it is ordered in writing by the beneficiary's attending physician.

(i) Limitations on coverage of screening barium enemas. (1) In the case of an individual age 50 or over who is not at high risk of colorectal cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

(2) In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

[62 FR 59100, Oct. 31, 1997, as amended at 66 FR 55329, Nov. 1, 2001; 67 FR 80040, Dec. 31, 2002; 77 FR 69362, Nov. 16, 2012; 78 FR 74811, Dec. 10, 2013]

APPENDIX E
MEDICARE DIAGNOSTIC TEST POLICIES

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Title 42: Public Health
PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS
Subpart B—Medical and Other Health Services

§410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

(a) *Ordering diagnostic tests.* All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (see §411.15(k)(1) of this chapter).

(1) *Mammography exception.* A physician who meets the qualification requirements for an interpreting physician under section 354 of the Public Health Service Act as provided in §410.34(a)(7) may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary.

(2) *Application to nonphysician practitioners.* Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries for the purpose of this paragraph.

(b) *Diagnostic x-ray and other diagnostic tests*—(1) *Basic rule.* Except as indicated in paragraph (b)(2) of this section, all diagnostic x-ray and other diagnostic tests covered under section 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 section 1861(r) of the Act. Services furnished without the required level of supervision are not reasonable and necessary (see §411.15(k)(1) of this chapter).

(2) *Exceptions.* The following diagnostic tests payable under the Physician Fee Schedule are excluded from the basic rule set forth in paragraph (b)(1) of this section:

(i) Diagnostic mammography procedures, which are regulated by the Food and Drug Administration.

(ii) Diagnostic tests personally furnished by a qualified audiologist as defined in section 1861(ll)(3) of the Act.

(iii) Diagnostic psychological and neuropsychological testing services when—

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician or a clinical psychologist.

(iv) Diagnostic tests (as established through program instructions) personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist and permitted to provide the service under State law.

(v) Diagnostic tests performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

(vi) Pathology and laboratory procedures listed in the 80000 series of the Current Procedural Terminology published by the American Medical Association.

(vii) Diagnostic tests performed by a certified nurse-midwife authorized to perform the tests under applicable State laws.

(3) *Levels of supervision.* Except where otherwise indicated, all diagnostic x-ray and other diagnostic tests subject to this provision and payable under the Physician Fee Schedule must be furnished under at least a general level of physician supervision as defined in paragraph (b)(3)(i) of this section. In addition, some of these tests also require either direct or personal supervision as defined in paragraphs
(b)(3)(ii) or (b)(3)(iii) of this section, respectively. (However, diagnostic tests performed by a physician assistant (PA) that the PA is legally authorized to perform under State law require only a general level of physician supervision.) When direct or personal supervision is required, physician supervision at the specified level is required throughout the performance of the test.

(i) *General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

(ii) *Direct supervision* in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

(iii) *Personal supervision* means a physician must be in attendance in the room during the performance of the procedure.

(c) Portable x-ray services. Portable x-ray services furnished in a place of residence used as the patient's home are covered if the following conditions are met:

(1) These services are furnished under the general supervision of a physician, as defined in paragraph (b)(3)(i) of this section.

(2) These services are ordered by a physician as provided in paragraph (a) or by a nonphysician practitioner as provided in paragraph (a)(2) of this section.

(3) The supplier of these services meets the requirements set forth in part 486, subpart C of this chapter, concerning conditions for coverage for portable x-ray services.

(4) The procedures are limited to—

(i) Skeletal films involving the extremities, pelvis, vertebral column, or skull;

(ii) Chest or abdominal films that do not involve the use of contrast media; and

(iii) Diagnostic mammograms if the approved portable x-ray supplier, as defined in subpart C of part 486 of this chapter, meets the certification requirements of section 354 of the Public Health Service Act as implemented by 21 CFR part 900, subpart B.

(d) *Diagnostic laboratory tests*—(1) *Who may furnish services.* Medicare Part B pays for covered diagnostic laboratory tests that are furnished by any of the following:

(i) A participating hospital or participating RPCH.

(ii) A nonparticipating hospital that meets the requirements for emergency outpatient services specified in subpart G of part 424 of this chapter and the laboratory requirements specified in part 493 of this chapter.

(iii) The office of the patient's attending or consulting physician if that physician is a doctor of medicine, osteopathy, podiatric medicine, dental surgery, or dental medicine.

(iv) An RHC.

(v) A laboratory, if it meets the applicable requirements for laboratories of part 493 of this chapter, including the laboratory of a nonparticipating hospital that does not meet the requirements for emergency outpatient services in subpart G of part 424 of this chapter.

(vi) An FQHC.

(vii) An SNF to its resident under §411.15(p) of this chapter, either directly (in accordance with §483.75(k)(1)(i) of this chapter) or under an arrangement (as defined in §409.3 of this chapter) with another entity described in this paragraph.

(2) *Documentation and recordkeeping requirements*—(i) *Ordering the service.* The physician or (qualified nonphysican practitioner, as defined in paragraph (a)(2) of this section), who orders the service must maintain documentation of medical necessity in the beneficiary's medical record.

(ii) *Submitting the claim.* The entity submitting the claim must maintain the following documentation:

(A) The documentation that it receives from the ordering physician or nonphysician practitioner.

(B) The documentation that the information that it submitted with the claim accurately reflects the information it received from the ordering physician or nonphysician practitioner.

(iii) *Requesting additional information.* The entity submitting the claim may request additional diagnostic and other medical information to document that the services it bills are reasonable and necessary. If the entity requests additional documentation, it must request material relevant to the medical necessity of the specific test(s), taking into consideration current rules and regulations on patient confidentiality.

(3) *Claims review.* (i) *Documentation requirements.* Upon request by CMS, the entity submitting the claim must provide the following information:

(A) Documentation of the order for the service billed (including information sufficient to enable CMS to identify and contact the ordering physician or nonphysician practitioner).

(B) Documentation showing accurate processing of the order and submission of the claim.

(C) Diagnostic or other medical information supplied to the laboratory by the ordering physician or nonphysician practitioner, including any ICD-9-CM code or narrative description supplied.

(ii) *Services that are not reasonable and necessary.* If the documentation provided under paragraph (d)(3)(i) of this section does not demonstrate that the service is reasonable and necessary, CMS takes the following actions:

(A) Provides the ordering physician or nonphysician practitioner information sufficient to identify the claim being reviewed.

(B) Requests from the ordering physician or nonphysician practitioner those parts of a beneficiary's medical record that are relevant to the specific claim(s) being reviewed.

(C) If the ordering physician or nonphysician practitioner does not supply the documentation requested, informs the entity submitting the claim(s) that the documentation has not been supplied and denies the claim.

(iii) *Medical necessity.* The entity submitting the claim may request additional diagnostic and other medical information from the ordering physician or nonphysician practitioner to document that the services it bills are reasonable and necessary. If the entity requests additional documentation, it must request material relevant to the medical necessity of the specific test(s), taking into consideration current rules and regulations on patient confidentiality.

(4) *Automatic denial and manual review.* (i) *General rule.* Except as provided in paragraph (d)(4)(ii) of this section, CMS does not deny a claim for services that exceed utilization parameters without reviewing all relevant documentation that is submitted with the claim (for example, justifications prepared by providers, primary and secondary diagnoses, and copies of medical records).

(ii) *Exceptions.* CMS may automatically deny a claim without manual review if a national coverage decision or LMRP specifies the circumstances under which the service is denied, or the service is specifically excluded from Medicare coverage by law.

(e) *Diagnostic laboratory tests furnished in hospitals and CAHs.* The provisions of paragraphs (a) and (d)(2) through (d)(4) of this section, inclusive, of this section apply to all diagnostic laboratory tests furnished by hospitals and CAHs to outpatients.

[62 FR 59098, Oct. 31, 1997, as amended at 63 FR 26308, May 12, 1998; 63 FR 53307, Oct. 5, 1998; 63 FR 58906, Nov. 2, 1998; 64 FR 59440, Nov. 2, 1999; 66 FR 58809, Nov. 23, 2001; 69 FR 66421, Nov. 15, 2004; 72 FR 66398, Nov. 27, 2007; 75 FR 73615, Nov. 29, 2010; 77 FR 69361, Nov. 16, 2012]

APPENDIX F
MEDICARE TELEHEALTH POLICIES

(HCPCS) codes are listed *on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/*

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

190.3.1 - Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits

(Rev. 2354, Issued: 11-18-11 Effective: 01-01-12, Implementation: 01-03-12)

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source.

Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient or emergency department consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site.

The use of a telecommunications system may substitute for an in-person encounter for emergency department or initial and follow-up inpatient consultations.

Medicare A/B MACs (B) pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met:

- An inpatient or emergency department consultation service is distinguished from other inpatient or emergency department evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices;

- A request for an inpatient or emergency department telehealth consultation from an appropriate source and the need for an inpatient or emergency department telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the

requesting physician or qualified NPP's plan of care in the patient's medical record; and

- After the inpatient or emergency department telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

Unlike inpatient or emergency department telehealth consultations, the majority of subsequent inpatient hospital, emergency department and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

190.3.2 - Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined

(Rev. 2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

Emergency department or initial inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the emergency department or initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the emergency department or initial inpatient telehealth consultation would be distinct from the care provided by the physician of record or the attending physician. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Emergency department or initial inpatient telehealth consultations are subject to the criteria for emergency department or initial inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for emergency department or initial inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care

plans to other health care professionals. No additional E/M service could be billed for work related to an emergency department or initial inpatient telehealth consultation.

Emergency department or initial inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth).

- Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth).

Although emergency department or initial inpatient telehealth consultations are specific to telehealth, these services must be billed with either the -GT or -GQ modifier to identify the telehealth technology used to provide the service. See section 190.6 of this chapter for instructions on how to use these modifiers.

190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined

(Rev. 2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs (B), 04-04-11 A/B MACs (A))

Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in-person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs.

The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up

inpatient consultation would be distinct from the follow-up care provided by the physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation. Follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include at least two of the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional evaluation and management service could be billed for work related to a follow-up inpatient telehealth consultation.

Follow-up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth).

- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code G0407(Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth).

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either the -GT or -GQ modifier to identify the telehealth technology used to provide the service. (See section 190.6 of this chapter for instructions on how to use these modifiers.)

190.3.4 – Payment for ESRD-Related Services as a Telehealth Service

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face "hands on" to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit, including a clinical examination of the vascular access site, must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter.

190.3.6 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

Individual and group DSMT services may be paid as a Medicare telehealth service; however, at least 1 hour of the 10 hour benefit in the year following the initial DSMT service must be furnished in-person to allow for effective injection training. The injection training may be furnished through either individual or group DSMT services. By reporting the –GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner certifies that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service.

As specified in 42 CFR 410.141(e) and stated in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 300.2, individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 190.6 of this chapter, Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed PA, NP, CNS, CNM , clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

190.4 - Conditions of Payment
(Rev. 1, 10-01-03)

1. Technology

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

2. Exception to the interactive telecommunications requirement

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous "store and forward technology" in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

3. "Store and forward" defined

For purposes of this instruction, "store and forward" means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

NOTE: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

4. Telepresenters

A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

190.5 - *Originating Site Facility Fee Payment Methodology*
(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

1. Originating site defined

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

2. Facility fee for originating site

The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee was the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.

3. Payment amount:

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below.

Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the OPPS. Payment is not based on the OPPS payment methodology.

Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).

Critical access hospitals. When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When

an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, regardless of geographic location. The A/B MAC (B) shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

Hospital-based or critical access-hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For A/B MAC (B) processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service.

Independent and provider-based RHCs and FQHCs bill the appropriate A/B/MAC (A) using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. All RHCs and FQHCs must use revenue code 078X when billing for the

originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base provider's bill type and billing number. Independent RHCs and FQHCs must bill the A/B MAC (B) for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit using revenue code 078X.

Hospital-based or CAH-based renal dialysis centers (including satellites) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Skilled nursing facilities (SNFs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X when billing for the originating site facility fee. The SNF serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Community mental health centers (CMHCs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in CMHCs must be submitted on a 76X TOB. All CMHCs must use revenue code 078X when billing for the originating site facility fee. The CMHC serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

190.6 - *Payment Methodology for Physician/Practitioner at the Distant Site*

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

1. Distant Site Defined

The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

2. Payment Amount (professional fee)

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

3. Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a site other than where beneficiary is)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. When the physician or practitioner at the distant site is licensed under state law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

If the physician or practitioner at the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH, the CAH bills its regular A/B/MAC (A) for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

4. Medicare Practitioners Who May Bill for Covered Telehealth Services are Listed Below (subject to State law)

Physician
Nurse practitioner
Physician assistant
Nurse-midwife
Clinical nurse specialist
*Clinical psychologist**
*Clinical social worker**
Registered dietitian or nutrition professional
Certified registered nurse anesthetist

**Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.*

APPENDIX G
MEDICARE POLICIES ON OUTPATIENT PHYSICAL THERAPY

5. Plan of Treatment

We are proposing to revise Secs. 410.61(e), 424.24(c)(4)(i), and 485.711(b), which concern the plan of treatment review requirements for outpatient rehabilitation therapy services. Section 1861(p) of the Act defines these therapy services, in part, as services furnished to an individual who is under the care of a physician and for whom a plan, prescribing the type, amount, and duration of therapy services that are to be furnished, has been established by a physician or a qualified therapist and is periodically reviewed by a physician.

Currently, providers that furnish outpatient rehabilitation therapy services are required to have a physician review the plan of treatment and recertify the need for care at least every 30 days. We proposed revising our policy to allow the physician to review and recertify the required plan of treatment within the first 62 days and at least every
31 days after the first review and recertification. The current requirement for the review of a plan of treatment for patients of physical therapists in independent practice is similar in that the physician must review the plan at least every 30 days. We proposed changing this review requirement and requiring that the physician review and recertify the plan of treatment within the first 62 days and at least every 31 days thereafter.

We recommended these changes because it was our understanding that
an initial 2-month (62 day) review is consistent with the usual therapy course of treatment. It is also consistent with our current therapy requirements in the home health setting. These changes were intended to reduce the burden on providers, patients, and physicians by eliminating the current requirement for an initial review within the first 30 days.
After the first 62 days, we believed that patients receiving outpatient rehabilitation services are likely to show significant progress that warrants subsequent reviews every 31 days. Changes in the patient's level of function and need for continued therapy can be expected to occur more frequently after the first 2 months of therapy. We believe this subsequent review schedule will help control potential over-utilization that results in excessive therapy to some Medicare patients.

Under our proposed policy, the therapists would be required to immediately notify the physician of any changes in the patient's condition, and physicians retain the ability to review the care at closer intervals if necessary.

Comment: We received comments from six outpatient rehabilitation associations supporting our proposal and two comments from orthopedic surgical associations strongly opposing it. The opposing orthopedic associations informed us that 62 days is not the usual course of treatment. They argued that every patient's need for therapy is unique depending on the condition. While 62 days may be appropriate for some back injuries, they contend it would be inappropriate for a hand, foot, or shoulder injury. Therapy is appropriate as long as the patient continues to make progress and should be discontinued when the patient's condition has plateaued and no further progress is being made. They stated this can best be determined by the referring physician periodically evaluating the patient's progress and recovery. They believe the current 30-day requirement is appropriate and should be maintained.

Response: After careful review of the comments received and study of the issue by our medical staff, we are retaining our current 30-day requirement and rescind our proposal. As indicated above, our intent, in part, was to establish consistency with the initial review period for HHA therapy services. However, subsequent to our proposal we further learned that HHA patients may not receive the same level of intensity of therapy services as patients receiving them under the outpatient rehabilitation benefit. Our medical staff believes that patients in the latter group are seen more often by their therapists than are HHA patients. Therefore, the rate of progression between the two patient groups may be different and warrant a 30-day rather 62-day initial plan of treatment review for beneficiaries receiving outpatient rehabilitation services.

Comment: We received several comments to allow nonphysician practioners such as nurse practitioners, physician assistants, and clinical nurse specialist to certify the therapy plan of care.

Response: Because we allow nonphysician practioners, that is, nurse practitioners, clinical

nurse specialists, and physician assistants to prescribe medicine, we have also decided that nonphysician practioners who have knowledge of the therapy case may certify therapy plans of treatment.

Result of the evaluation of comments: We are adopting our proposal to pay all outpatient rehabilitation services and CORF services under the Physician Fee Schedule. We are delaying full implementation of the financial limitations on outpatient rehabilitation services furnished by nonhospital entities due to our Y2K efforts until after January 1, 2000. We are not adopting a site-of-service differential for outpatient rehabilitation providers as recommended by commenters. Regarding proposed qualifications for therapists, we are adopting them as proposed and are not accepting the recommendation that we require occupational therapists to provide evidence of successful completion of a national certification examination. We anticipate that this issue will be further studied and discussed in a subsequent rule. We are withdrawing our proposal to extend from 30 days to 60 days the time required for physician recertification of the plan of treatment.

Payment for Services of Certain Nonphysician Practitioners and Services Furnished Incident-to Their Professional Services

Nonphysician practitioners' services have been covered by Medicare since the inception of the program; originally the law did not provide for separate payments for these services. Coverage and payment of nonphysicians' services was primarily within the context of section 1861(s)(2)(A) of the Act as implemented by section 2050 of the Medicare Carriers Manual, for the payment of services incident-to a physician's professional services. In recent years, the Congress has expanded Medicare coverage of nonphysician practitioners' services in certain settings to improve beneficiary access to medical services. Separate Part B coverage is specifically authorized for certain nonphysician practitioners' services and for services and supplies furnished as incident-to those services.

For purposes of this rule as it applies to nonphysician practitioners, we define nonphysician practitioners as nurse practitioners, clinical nurse specialists, certified nurse-midwives, and physician assistants. With respect to services and supplies furnished as incident-to a nonphysician practitioner's services, we are requiring that, to be covered by Medicare, the services must meet the longstanding requirements in section 2050 of the Medicare Carriers

Manual applicable to services furnished as incident-to the professional services of a physician. Therefore, we specify, in new Secs. 410.74(b), 410.75(d), 410.76(d), and 410.77(c) that Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) furnished as incident-to the nonphysician's services only if these services and supplies would be covered if furnished by a physician or furnished as incident-to a physician's professional services. In addition, Secs. 410.74(b), 410.75(d), 410.76(d), and 410.77(c) specify the various requirements for these incidental services and supplies.

Coverage and Payment for Nurse Practitioners' Services Subsequent to BBA

Effective for services furnished on or after January 1, 1998, section 4511 of BBA authorizes nurse practitioners to bill the program directly for services furnished in any setting, regardless of whether the settings are located in rural or urban areas, but only if the facility or other providers of services do not charge or are not paid any amounts with respect to the furnishing of nurse practitioners' services. Accordingly, a new Sec. 410.75 of this rule specifies the qualifications for nurse practitioners, lists the requirements for the professional services of a nurse practitioner and the requirements for services furnished incident-to the professional services of a nurse practitioner. This new section also specifies the process that applies to the provision of nurse practitioners' services.

New Secs. 405.520(a), (b), and (c) of this rule provide the general rule and requirements for nurse practitioners. A new paragraph (16) is added to Sec. 410.150(b) to authorize payment for nurse practitioners' services when furnished in collaboration with a physician in all settings located in both rural and urban areas. A new paragraph (c) is added to Sec. 414.56 of this rule to set forth the payment amount for nurse practitioner services.

All of the independent nurse practitioners and clinical nurse specialists commenting on the proposed rule and all of the major organizations representing these nonphysician practitioners vigorously opposed the proposed Federal guidelines for

APPENDIX H
MEDICARE POLICY ON ORDERING DME AND SIGNING CMN

Medicare Program Integrity Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 4 **Date: JANUARY 31, 2001**

CHANGE REQUEST 1471

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
Chapter 5	Table of Contents	---	---
Chapter 5	---	Section 1.1.6	---

NEW/REVISED MATERIAL--EFFECTIVE DATE: July 1, 2001
IMPLEMENTATION DATE: January 31, 2001

This change adds Section 1.1.6 to Chapter 5 of the Program Integrity Manual.

Chapter 5, Section 1.1.6 Physician Assistant Rules Concerning Orders and CMNs is a new section allowing physician assistants to sign certificates of medical necessity and orders.

NOTE: Red italicized font identifies new material.

These instructions should be implemented within your current operating budget.

MEDICARE PROGRAM INTEGRITY MANUAL

Chapter 5 – Items and Services Having Special DMERC Review Considerations

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Table of Contents

1.1.6 – Physician Assistant Rules Concerning Orders and CMNs -- (Rev. 4, 01-31-01)

Physician assistants may provide the dispensing order and write and sign the detailed written order if they satisfy all the following requirements:

- ***They meet the definition of physician assistant found in §1861(aa)(5)(A) of the Act and §2156(A) of the Medicare Carriers Manual;***
- ***They are treating the beneficiary for the condition for which the item is needed;***
- ***They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;***
- ***They have their own UPIN; and***
- ***They are permitted to perform services in accordance with State law.***

Physician assistants may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders.

APPENDIX I
OBTAINING AN NPI

Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: N/A
MLN Matters Number: SE0528
Related CR Release Date: N/A

CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs

Note: This article was updated on February 26, 2013, to reflect current Web addresses. This article was previously revised on May 7, 2007, to add the statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5595.pdf on the CMS website. All other information remains unchanged.

Provider Types Affected

All health care providers - Medicare and non-Medicare

Provider Action Needed

Learn about the NPI and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims,

eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI. Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, it will be important to apply for your NPI before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The web address will be *https://nppes.cms.hhs.gov/NPPES/Welcome.do* but please note -- the web site is not available until May 23, 2005.

2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on *https://nppes.cms.hhs.gov/NPPES/Welcome.do* or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer . The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

Visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html on the CMS website.

Beginning May 23, 2005, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to *http://AskHIPAA@cms.hhs.gov/* on the Internet.

APPENDIX J1
"INCIDENT-TO" BILLING

BY MICHAEL POWE

Incident-To Billing

Still Relevant? Still Legal?

"INCIDENT-TO" is a Medicare program billing option that has been in place for decades. Originally established to account for the ancillary services provided by RNs, LPNs and medical assistants, such as injections and blood pressure readings, it was adapted to allow higher-level services delivered by PAs and NPs to be reported at a time when there was no payment category to cover those services.

Incident-to billing allows office or clinic services performed by a PA to be billed under the name of the PA's supervising physician. The bill for the PA's services is submitted to Medicare as if the service had been delivered by the physician. This allows the service to be paid at 100 percent of the Medicare physician fee schedule, as opposed to payment at 85 percent if the service is billed under the PA's name. Practices that utilize incident-to billing should be certain that the rules and additional supervision requirements are clearly understood and applied.

Medicare billing for incident-to services applies only to the private office or clinic setting. Under Medicare's rules, incident-to billing should not be used in the hospital or nursing home setting. In very rare instances, it may be possible to have a private office or clinic located in a nursing home or hospital setting.

Incident-to billing requires that the physician examine, diagnose and establish a treatment plan for a particular medical problem, or for an established patient who presents with a new medical problem. PAs can provide subsequent or follow-up care for the patient during future visits and bill those subsequent services under the physician's name as long as a physician is in the suite of offices. On that first visit, the PA or another member of the physician's staff may perform the past, family and social history and the review of systems. However, it is important that the history of present illness, the exam and the medical decision making be performed by the physician. (or repeated, if previously performed by the PA before the physician sees the patient).

In addition, the supervising physician (or another physician member of the same group) must be physically present in the office suite when the PA renders a subsequent service. Medicare does not require that a physician be in the same exam room or personally treat the patient when PAs deliver subsequent care. It would not be appropriate for the physician to be in another building or across the street at the hospital when the services of the PA are being billed incident to that physician.

If the practice meets the criteria, the visit may be billed under the physician's name. If you are working in a group, bill under the physician who is physically on site and providing supervision at the time of the PA service. For example, if Dr. Smith examined the patient on the first visit and developed a plan of care for hypertension, but Dr. Johnson is on site when the PA treats the patient on a follow-up visit for that same condition, bill the service under Dr. Johnson.

Medicare does not require that PAs bill their services under the incident-to provision. PAs can treat all Medicare patients (new patients or established patients with a new medical problem) and bill under their own provider numbers. When you bill under the PA's name, Medicare does not require that a physician be on site when care is provided. State law will determine supervision. Reimbursement is made to the PA's employer at 85 percent of the fee schedule. When billing

PAs can treat all Medicare patients (new patients or established patients with a new medical problem) and bill under their own provider numbers.

PHOTOS / TODD SPOTH

a service under the PA's name, always bill at the full physician rate. Use of the PA's name and national provider identification number will alert Medicare to pay at the 85 percent rate.

Medicare regulations also indicate that the physician should remain involved in the patient's ongoing care to demonstrate his or her participation in the care of the patient. While the program does not specify how that should be accomplished, it would be reasonable to suggest that a periodic examination by the physician would be appropriate. Some would also propose that having the physician review the patient's chart would also meet the standard.

Incident-to is a billing concept that is often misunderstood. Improper use of incident-to billing may lead to allegations of fraud and abuse. Because of potential confusion and concerns about fraud and abuse, many practices have decided not to use incident-to billing and simply allow PAs to bill under their own names. Under that scenario, billing is simplified, the potential for fraud and abuse reduced, and in many instances patients flow through the practice more efficiently. The belief is that patient volume grows and patient waiting time goes down. To those practices, those advantages make up for the 15 percent payment differential.

Finally, realize that incident-to is a Medicare term that is often used by private payers to mean something else. Private payers often don't have the same requirements as Medicare for the initial physician exam and the on-site presence of the physician. The majority of private payers use incident-to to indicate that the PA's services should be billed under the supervising physician's name. In most cases, the private payers defer to state law regarding the ability of PAs to perform the initial exam and physician supervision can be satisfied with cell phone access between the physician and the PA. However, Aetna, one of the larger private payers in the market, has adopted the Medicare incident-to billing requirements.

The key is to realize that there is not a one-size-fits-all model for reimbursement. It is essential that you know the specific billing rules for each payer in your market. **PA**

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The key is to realize that there is not a one-size-fits-all model for reimbursement. It is essential that you know the specific billing rules for each payer in your market.

APPENDIX J2
"INCIDENT-TO" BILLING

Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1764 **Date: AUGUST 28, 2002**

CHANGE REQUEST 2222

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2050.1 – 2050.3	2-19 - 2-22 (4 pp.)	2-19 - 2-22 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: August 28, 2002*
IMPLEMENTATION DATE: August 28, 2002

Section 2050, Services and Supplies, is revised to implement new regulations at 42 CFR 410.26 on services and supplies furnished incident to a physician's services. Section 410.26(a)(7) indicates that the incident to requirements do not apply to services, such as clinical diagnostic tests, that have their own benefit category in the statute.

Section 2050.1, Incident to Physician's Professional Services, revises the incident to supervision and employment requirements so that both the supervising physician and the auxiliary personnel furnishing the service may be an employee, a leased employee or an independent contractor of the physician or legal entity billing and receiving payment for the services.

Sections 2050.2, Services of Nonphysician Personnel Furnished Incident to Physicians Services, and 2050.3, Incident to Physician's Service in Clinic, are revised to comply with the use of the terms "auxiliary personnel" and "direct supervision" in regulations §§410.26(a)(1) and 410.32(b)(3)(ii).

Section 2050.3, Incident to Physician's Service in Clinic, revised to indicate that auxiliary personnel must be supervised by clinic physicians.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

2050. SERVICES AND SUPPLIES

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services, are commonly included in the physician's or practitioner's bills, and for which payment is not made under a separate benefit category listed in §1861 (s) of the Act. Carriers should not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861 (s)(3) of the Act and are subject to the coverage requirements in §2070. Depending on the particular tests, the supervision requirement in §2070 may be more or less stringent than that discussed in §2050.1.B. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861 (s)(10) of the Act and need not also meet incident to requirements. (Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel (see §2050.1.B.) under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements would apply (see §2050.2)).

Certain hospital services may also be covered as incident to a physician's services under §1861(s)(2)(B) of the Act. Payment for these services is made under Part B to a hospital by the hospital's intermediary and are not subject to the same requirements as services covered under §1861(s)(2)(A).

For purposes of this section, physician means physician or other practitioner (physician assistant, §2156; nurse practitioner, §2158; clinical nurse specialist, §2160; nurse midwife, §2154; and clinical psychologist, §2150) authorized by the Act to receive payment for services incident to his or her own services.

To be covered incident to the services of a physician, services and supplies must be:

- o An integral, although incidental, part of the physician's professional service (see §2050.1);
- o Commonly rendered without charge or included in the physician's bill (see §2050.1A);
- o Of a type that are commonly furnished in physician's offices or clinics (see §2050.1A);
- o Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §2050.1B).

2050.1 Incident to Physician's Professional Services.--Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

A. Commonly Furnished in Physicians' Offices.--Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.

Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians' bills. (See §2049 regarding coverage of drugs and biologicals under this

provision.) To be covered, supplies, including drugs and biologicals, must be an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the drug is not covered.

B. Direct Personal Supervision.--Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment in §3060. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every nonphysician service.)

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision. (See §45-15 of the Coverage Issues Manual for instructions used if a physician maintains an office in an institution.) For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) of the Social

Security Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary. For services in a hospital, see §2390. (See §2070 concerning physician supervision of technicians performing diagnostic x-ray procedures in a physician's office.)

2050.2 Services of Nonphysician Personnel Furnished Incident to Physician's Services.--In addition to coverage being available for the services of such auxiliary personnel as nurses, technicians, and therapists when furnished incident to the professional services of a physician, a physician may also have the services of certain nonphysician practitioners covered as services incident to a physician's professional services. These nonphysician practitioners, who are being licensed by the States under various programs to assist or act in the place of the physician, include, for example, certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists. (See §§2150 through 2160 for coverage instructions for various allied health/nonphysician practitioners' services.)

Services performed by these nonphysician practitioners incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician himself or herself such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition.

Nonetheless, in order for services of a nonphysician practitioner to be covered as incident to the services of a physician, the services must meet all of the requirements for coverage specified in §§2050 through 2050.1. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

A nonphysician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able (see §§2156 or 2158, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service. As explained in §2050.1, this does not mean that each occasion of an incidental service performed by a nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

Note also that a physician might render a physician's service that can be covered even though another service furnished by a nonphysician practitioner as incident to the physician's service might not be covered. For example, an office visit during which the physician diagnoses a medical problem and established a course of treatment could be covered even if, during the same visit, a nonphysician practitioner performs a noncovered service such as an acupuncture.

2050.3 Incident to Physician's Service in Clinic.--Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described above.

A physician directed clinic is one where (a) a physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open; (b) each patient is under the care of a clinic physician; and (c) the nonphysician services are under medical supervision.

In highly organized clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by auxiliary personnel are covered even though they are performed in another department of the clinic.

Supplies provided by the clinic during the course of treatment are also covered. When the auxiliary personnel perform services outside the clinic premises, the services are covered only if performed under the direct supervision of a clinic physician. If the clinic refers a patient for auxiliary services performed by personnel who are not supervised by clinic physicians, such services are not incident to a physician's service.

APPENDIX K
SHARED VISITS FOR E/M SERVICES

Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1776 **Date: OCTOBER 25, 2002**

CHANGE REQUEST 2321

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15360 – 15501 (Cont.)	15-73 - 15-74.2 (4 pp.)	15-73 - 15-74.1(3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2001*
IMPLEMENTATION DATE: October 25, 2002

Section 15501 Evaluation and Management Service Codes – General. Subsection B is revised to address payment for E/M services provided by physicians and non-physician practitioners (NPP) and also shared evaluation and management services between a physician and an NPP in the same group practice. (Also restores language erroneously deleted from the first paragraph of subsection A.)

Carriers need not search their files to either retract payment for claims already paid or to retrospectively pay claims.

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These instructions should be implemented within your current operating budget.

C. Therapy Assistants as Clinical Instructors.--Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors (CIs) for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

D. Services Provided Under Part A and Part B.--The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or RUG category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

15350. DIALYSIS SERVICES (CODES 90935-90999)

A. ESRD Monthly Capitation Payments.--Effective January 1, 1995, monthly capitation payments are made under the physician fee schedule. For their adult patients, physicians may bill either the monthly code (CPT code 90921) or the daily code (CPT code 90925) with units that represent the number of days in a single month, but may not bill both.

To bill for a month of services for pediatric patients, providers should bill the appropriate monthly code (CPT codes 90918, 90919, or 90920). To bill for less than a month of service, providers bill the appropriate daily code (CPT codes 90922-90925) and units that represent the number of days. Providers may bill either the monthly code or the daily code, but not both. Since billing is done at the conclusion of the month, the patient's age at the end of month is the age of the patient for billing purposes.

B. Inpatient Dialysis On Same Date As Evaluation and Management.--Payment for certain evaluation and management services (CPT codes 99231 through 99233, subsequent hospital visits, and CPT codes 99261 through 99263, follow-up inpatient consultations) is considered bundled into the payment for inpatient dialysis (CPT codes 90935 through 90947) when both are performed on the same day by the same physician for the same beneficiary. Do not pay a physician for both dialysis and a subsequent hospital visit or a follow-up inpatient consultation on the same date of service. If both are billed, pay the dialysis service and deny the evaluation and management service.

Separate payment may be made for an initial hospital visit (CPT codes 99221 through 99223), an initial inpatient consultation (CPT codes 99251 through 99255), and a hospital discharge service (CPT codes 99238 and 99239) when billed for the same date as an inpatient dialysis service. These services may be billed with a modifier -25 to indicate that they are significant and identifiable services.

Payment is not allowed for more than one inpatient dialysis service per day.

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

A. Separate Payment for Contrast Media.--Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of injectable contrast material for use in echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

B. Chemotherapy Administration By Push and Infusion On Same Day.--Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Allow only one push administration on a single day.

C. Chemotherapy Infusion and Hydration Therapy Infusion On Same Day.--Separate payment is not allowed for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate payment is allowed for these two services on the same day when they are provided sequentially, rather than at the same time. Physicians use the modifier -GB to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

D. Chemotherapy Administration and "Incident To" Services on Same Day.--On days when a patient receives chemotherapy administration but the physician has no face-to-face contact with the patient, the physician may report and be paid for "incident to" services furnished by one of the physician's employees, in addition to the chemotherapy administration, if they are furnished under direct personal supervision in the office by one of the physician's employees and the medical records reflect the physician's active participation in and management of the course of treatment. The correct code for this service is 99211.

E. Flushing Of Vascular Access Port.--Flushing of a vascular access port prior to administration of chemotherapy is integral to the chemotherapy administration and is not separately billable. If a special visit is made to a physician's office just for the port flushing, code 99211, brief office visit, should be used. Code 96530, refilling and maintenance of implantable pump or reservoir, while a payable service, should not be used to report port flushing.

F. Chemotherapy Administration and Hydration Therapy.--Do not pay separately for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under codes 90780 and 90781 when these drugs are administered at the same time as chemotherapy infusion, codes 96410, 96412, or 96414. However, pay for the infusion of saline, antiemetics, or other nonchemotherapy drugs under codes 90780 and 90781 when these drugs are administered on the same day but sequentially to rather than at the same time as chemotherapy infusion, codes 96410, 96412, and 96414. Physicians should use modifier GB to indicate when codes 90780 and 90781 are provided sequentially rather than contemporaneously with codes 96410, 96412, and 96414. Both the chemotherapy and the nonchemotherapy drugs are payable regardless of whether they are administered sequentially or contemporaneously.

15501. EVALUATION AND MANAGEMENT SERVICE CODES - GENERAL (CODES 99201-99499)

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be

within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level Of Evaluation and Management Service.--Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (see §§2050.1, 2050.2 and 15501 Subsection G).

Office/Clinic Setting.-- In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting.--When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Examples of Shared Visits:

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The carrier has the discretion to

value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling.--Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

APPENDIX L1
LIST OF MEDICARE EXCLUDED CODES FOR FIRST ASSIST

The following is a list of procedure codes for which Medicare will not reimburse a first-assistant-at-surgery in 2018. The list consists of procedures that Medicare has determined required a first-assistant-at-surgery in fewer than 5% of the cases nationally. The list applies to all first assistants - PAs, MDs, and NPs.

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
G0104	11404	11900	14020	15630	17270	20245	21120	23350
G0105	11406	11901	14021	15730	17271	20250	21210	23415
G0105	11420	11960	14040	15733	17272	20500	21215	23480
G0121	11421	11970	14041	15736	17273	20501	21235	23500
G0121	11422	11980	14060	15740	17274	20520	21248	23505
G0127	11423	12001	14061	15760	17276	20525	21282	23540
G0168	11424	12002	15040	15777	17280	20526	21310	23570
G0268	11426	12004	15050	15781	17281	20527	21315	23600
0228T	11440	12005	15100	15786	17282	20550	21320	23605
0229T	11441	12006	15101	15787	17283	20551	21335	23620
0230T	11442	12007	15110	15788	17284	20552	21346	23625
0231T	11443	12011	15111	15789	17286	20553	21461	23650
0232T	11444	12013	15115	15822	17311	20600	21480	23655
0308T	11446	12014	15116	15823	17312	20604	21501	23665
0479T	11450	12015	15120	15840	17313	20605	21550	23675
0499T	11470	12016	15121	15851	17314	20606	21555	23700
10040	11600	12020	15130	15852	17315	20610	21556	23921
10060	11601	12021	15131	15931	17340	20611	21820	23930
10061	11602	12031	15135	15934	17360	20612	21920	23931
10080	11603	12032	15136	15936	19000	20615	21925	24065
10081	11604	12034	15150	15937	19001	20650	21930	24066
10120	11606	12035	15151	15940	19020	20660	21935	24075
10121	11620	12036	15152	15946	19030	20661	22015	24076
10140	11621	12041	15155	15950	19100	20664	22310	24077
10160	11622	12042	15156	15953	19101	20670	22315	24105
10180	11623	12044	15157	15956	19105	20690	22505	24110
11000	11624	12045	15200	15958	19110	20693	22510	24130
11001	11626	12051	15201	16000	19120	20694	22511	24136
11004	11640	12052	15220	16020	19125	20920	22512	24145
11006	11641	12053	15221	16025	19126	20926	22513	24147
11010	11642	12054	15240	16030	19300	20931	22514	24160
11011	11643	12055	15241	16035	19328	20974	22515	24164
11012	11644	13100	15260	16036	19330	20979	23030	24201
11042	11646	13101	15261	17000	19340	20982	23031	24300
11043	11719	13102	15271	17003	19350	20983	23044	24332
11044	11720	13120	15272	17004	19370	21015	23065	24500
11055	11721	13121	15273	17106	19371	21025	23066	24505
11056	11730	13122	15274	17107	19380	21026	23075	24530
11057	11732	13131	15275	17110	20005	21030	23076	24535
11100	11740	13132	15276	17111	20101	21031	23101	24538
11101	11750	13133	15277	17250	20102	21032	23106	24560
11200	11760	13151	15278	17260	20200	21040	23130	24565
11201	11762	13152	15570	17261	20205	21079	23140	24566
11400	11765	13153	15572	17262	20206	21080	23170	24576
11401	11770	13160	15574	17263	20220	21089	23180	24577
11402	11771	14000	15576	17264	20225	21110	23334	24582
11403	11772	14001	15620	17266	20240	21116	23335	24600

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
24605	25652	26525	27222	27619	28011	28288	29345	30220
24650	25671	26535	27230	27630	28020	28310	29355	30300
24655	25931	26593	27232	27635	28022	28312	29358	30420
24670	26010	26600	27235	27640	28024	28313	29365	30520
24675	26011	26605	27238	27641	28035	28315	29405	30560
25000	26020	26615	27240	27652	28043	28340	29425	30580
25001	26034	26650	27246	27680	28046	28341	29435	30620
25020	26040	26665	27250	27681	28050	28344	29440	30801
25024	26045	26676	27252	27686	28052	28400	29445	30802
25028	26055	26685	27265	27695	28060	28430	29450	30901
25065	26070	26700	27266	27696	28062	28436	29505	30903
25066	26075	26706	27275	27704	28070	28450	29515	30905
25075	26080	26720	27301	27707	28072	28456	29530	30906
25076	26110	26725	27323	27726	28090	28465	29540	30915
25077	26115	26727	27324	27730	28092	28470	29550	30920
25109	26116	26735	27327	27732	28108	28475	29580	30930
25110	26117	26740	27328	27734	28110	28485	29700	31000
25111	26121	26742	27330	27750	28111	28490	29705	31020
25112	26123	26746	27340	27752	28112	28495	29720	31030
25115	26125	26750	27370	27760	28116	28496	29730	31032
25118	26130	26755	27425	27762	28119	28505	29740	31040
25150	26140	26765	27437	27766	28120	28510	29805	31050
25230	26145	26770	27475	27767	28124	28515	29806	31051
25246	26160	26775	27477	27768	28126	28531	29807	31070
25248	26205	26776	27485	27769	28140	28606	29819	31090
25259	26210	26785	27496	27780	28150	28636	29830	31200
25260	26215	26860	27500	27781	28153	28645	29848	31201
25290	26236	26861	27502	27784	28160	28660	29870	31231
25295	26320	26910	27508	27786	28173	28666	29871	31237
25337	26340	26951	27510	27788	28175	28675	29873	31253
25430	26341	26952	27516	27792	28190	28755	29876	31254
25445	26350	26989	27520	27808	28192	28820	29882	31255
25450	26356	26990	27530	27810	28193	28825	29886	31256
25455	26410	27000	27532	27816	28200	28890	29893	31257
25500	26416	27040	27560	27818	28208	29065	30020	31259
25505	26418	27041	27570	27824	28220	29075	30100	31267
25520	26426	27043	27594	27840	28222	29085	30110	31276
25530	26432	27047	27596	27842	28225	29086	30115	31500
25535	26433	27060	27600	27884	28226	29105	30117	31502
25560	26437	27062	27601	27886	28230	29125	30118	31505
25565	26440	27093	27603	27889	28232	29126	30120	31511
25600	26442	27095	27606	28001	28234	29130	30124	31515
25605	26445	27096	27607	28002	28240	29131	30130	31525
25606	26460	27185	27610	28003	28270	29200	30140	31526
25622	26476	27197	27613	28005	28272	29240	30150	31530
25630	26477	27200	27614	28008	28285	29260	30200	31535
25650	26520	27220	27618	28010	28286	29280	30210	31536

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
31540	31730	33263	36248	36800	37722	42104	43227	44100
31541	32400	33264	36251	36810	37735	42106	43229	44340
31545	32405	33270	36252	36815	37760	42107	43231	44360
31546	32550	33271	36253	36823	37765	42140	43232	44361
31570	32551	33272	36254	36835	37766	42145	43233	44366
31571	32554	33273	36260	36860	37780	42300	43235	44372
31575	32555	33282	36262	36861	37785	42330	43236	44373
31576	32556	33284	36400	36901	38300	42335	43237	44380
31579	32557	33420	36405	36902	38305	42400	43238	44381
31600	32560	33946	36406	36903	38500	42405	43239	44382
31603	32960	33947	36410	36904	38505	42505	43240	44384
31605	32997	33948	36425	36905	38510	42550	43241	44385
31610	32999	33949	36430	36906	38520	42650	43242	44386
31613	33010	33968	36455	36907	38525	42700	43243	44388
31614	33015	33971	36465	36908	38790	42800	43244	44388
31615	33202	33974	36466	36909	38792	42804	43245	44389
31622	33203	34471	36470	37140	39401	42806	43247	44390
31623	33206	34490	36471	37184	39402	42808	43248	44391
31624	33207	35207	36473	37185	40490	42809	43249	44392
31625	33208	35540	36474	37186	40500	42826	43250	44394
31628	33210	35875	36475	37187	40510	42962	43251	44401
31629	33211	36002	36476	37188	40520	42970	43252	44402
31630	33212	36010	36478	37191	40525	43180	43253	44403
31631	33213	36011	36479	37192	40530	43191	43254	44404
31632	33215	36012	36481	37193	40654	43192	43255	44405
31633	33216	36013	36482	37197	40761	43193	43257	44406
31635	33217	36014	36483	37200	40800	43194	43259	44407
31636	33218	36015	36500	37211	40801	43195	43260	44408
31637	33220	36100	36511	37212	40808	43196	43261	44799
31638	33221	36140	36512	37213	40810	43197	43262	45000
31640	33222	36160	36513	37214	40812	43198	43263	45005
31641	33224	36200	36514	37220	40814	43200	43264	45020
31643	33225	36215	36516	37241	40816	43201	43265	45100
31645	33226	36216	36522	37242	40820	43202	43266	45108
31646	33227	36217	36555	37243	41000	43204	43270	45190
31647	33228	36218	36556	37244	41100	43205	43274	45300
31648	33229	36221	36568	37246	41105	43206	43275	45303
31649	33230	36222	36569	37247	41108	43210	43276	45305
31651	33231	36223	36580	37248	41110	43211	43277	45308
31652	33233	36224	36584	37249	41112	43212	43278	45309
31653	33234	36225	36595	37500	41113	43213	43450	45315
31654	33235	36226	36596	37501	41116	43214	43453	45317
31660	33240	36227	36597	37607	41800	43215	43460	45320
31661	33241	36228	36600	37609	41825	43216	43499	45321
31717	33244	36245	36620	37650	41826	43217	43752	45327
31720	33249	36246	36625	37700	41827	43220	43760	45330
31725	33262	36247	36640	37718	42100	43226	43761	45331

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
45332	46255	47535	50395	52214	52647	54400	57420	61020
45333	46257	47536	50431	52224	52648	54401	57421	61026
45334	46260	47537	50432	52234	53000	54435	57452	61055
45335	46261	47538	50433	52235	53010	54450	57454	61070
45337	46262	47539	50434	52240	53020	54512	57455	61107
45338	46270	47540	50435	52250	53060	54520	57456	61108
45340	46275	47541	50553	52260	53080	54600	57460	61150
45341	46280	47542	50575	52265	53200	54620	57461	61151
45342	46285	47543	50590	52270	53240	54692	57500	61210
45346	46288	47544	50592	52275	53250	54700	57505	61215
45347	46320	47552	50606	52276	53260	54840	57510	61316
45349	46500	47553	50684	52281	53265	54860	57511	61517
45350	46505	47554	50688	52282	53270	55000	57513	61526
45378	46600	47555	50690	52283	53275	55040	57520	61530
45378	46601	47556	50693	52285	53420	55041	57522	61580
45379	46604	47999	50694	52287	53450	55100	57558	61581
45380	46606	48102	50695	52290	53502	55110	57800	61595
45381	46607	49060	50705	52305	53520	55250	58100	61623
45382	46608	49082	50706	52310	53600	55530	58120	61624
45384	46610	49083	51100	52315	53601	55540	58340	61626
45385	46611	49084	51101	52317	53605	55700	58346	61650
45386	46612	49180	51102	52318	53620	55705	58350	61651
45388	46614	49185	51600	52320	53621	55860	58353	61720
45389	46615	49250	51605	52325	53660	55870	58558	61735
45390	46700	49400	51610	52327	53661	55873	58559	61750
45391	46706	49402	51700	52330	53665	55874	58562	61751
45392	46753	49405	51701	52332	53850	55876	58565	61760
45393	46900	49406	51702	52334	53852	56405	58670	61770
45398	46910	49407	51703	52341	54001	56420	58671	61790
45399	46916	49419	51705	52342	54050	56440	58800	61888
45505	46917	49421	51710	52343	54055	56501	58999	62000
45520	46922	49422	51720	52344	54056	56515	59000	62148
45905	46924	49426	51726	52351	54057	56605	59001	62160
45910	46940	49428	51726	52352	54060	56606	59072	62190
45915	46945	49429	51726	52353	54065	56740	59200	62201
46020	46946	49904	51741	52354	54100	56820	59400	62225
46040	46947	49906	51741	52355	54105	56821	59410	62263
46045	47000	49999	51741	52356	54160	57061	59430	62264
46050	47001	50020	51784	52400	54161	57065	59510	62268
46060	47382	50040	51784	52402	54162	57100	59515	62270
46080	47383	50080	51784	52441	54163	57105	59812	62272
46083	47399	50200	52000	52442	54164	57135	59820	62273
46200	47490	50382	52001	52450	54200	57150	59897	62280
46220	47531	50384	52005	52500	54220	57155	60100	62281
46221	47532	50389	52007	52601	54230	57160	60300	62282
46230	47533	50390	52010	52630	54231	57180	61000	62284
46250	47534	50391	52204	52640	54235	57410	61001	62287

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
62290	64483	64783	65875	67110	67880	68525	69642	
62291	64484	64788	65880	67115	67882	68530	69643	
62294	64486	64795	65920	67120	67900	68540	69644	
62302	64487	64820	65930	67141	67901	68550	69645	
62303	64488	64821	66020	67145	67902	68700	69650	
62304	64489	64822	66030	67208	67903	68705	69660	
62305	64505	64823	66150	67210	67904	68760	69662	
62320	64510	64831	66155	67218	67906	68801	69676	
62321	64517	64856	66160	67220	67908	68810	69700	
62322	64520	65093	66225	67221	67909	68811	69714	
62323	64530	65101	66250	67225	67911	68815	69715	
62324	64550	65103	66500	67227	67912	68816	69717	
62325	64555	65125	66505	67228	67914	68840	69718	
62326	64561	65130	66600	67229	67915	68850	69806	
62327	64575	65135	66605	67250	67916	69000	69905	
62350	64581	65140	66625	67311	67917	69005	90867	
62367	64585	65155	66630	67312	67921	69020	90868	
62368	64590	65175	66635	67314	67922	69100	90869	
62369	64595	65205	66680	67318	67923	69105	94780	
62370	64600	65210	66682	67320	67924	69110	94781	
63615	64610	65220	66710	67331	67930	69120	96405	
63650	64612	65222	66711	67332	67935	69145	96406	
63688	64615	65272	66720	67334	67938	69150	96570	
64400	64616	65273	66740	67335	67950	69200	96571	
64402	64617	65285	66761	67343	67966	69205	96920	
64405	64620	65286	66762	67345	67971	69209	96921	
64413	64633	65290	66770	67400	67975	69210	96922	
64415	64634	65400	66820	67405	68020	69220	99170	
64416	64635	65420	66821	67412	68040	69222		
64417	64636	65426	66830	67500	68100	69310		
64418	64640	65430	66840	67505	68110	69420		
64420	64642	65435	66850	67515	68115	69421		
64421	64643	65436	66982	67550	68130	69424		
64425	64644	65450	66983	67700	68135	69433		
64430	64645	65600	66984	67710	68200	69436		
64435	64646	65772	66985	67715	68320	69440		
64445	64647	65775	66986	67800	68325	69501		
64446	64680	65780	66990	67801	68326	69535		
64447	64681	65782	67005	67805	68335	69540		
64448	64702	65785	67010	67808	68360	69604		
64449	64719	65800	67015	67810	68362	69610		
64450	64721	65810	67025	67820	68371	69620		
64461	64726	65815	67028	67825	68400	69631		
64462	64727	65850	67030	67830	68420	69632		
64463	64774	65855	67031	67840	68440	69633		
64479	64778	65865	67101	67850	68500	69635		
64480	64782	65870	67105	67875	68505	69641		

APPENDIX L2
LIST OF MEDICARE FIRST ASSIST CODES PAYABLE WITH SUPPORTING DOCUMENTATION

The following is a list of procedure codes for which Medicare will not reimburse a first-assistant-at-surgery in 2018 unless supporting documentation is submitted to establish medical necessity. The list applies to all first assistants - PAs, MDs, and NPs.

First Assistant Payable With Documentation Under Medicare for 2018

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
A4641	A9561	D7220	G0270	G0425	G9481	0163T	0270T	0406T
A4642	A9562	D7230	G0271	G0426	G9482	0164T	0271T	0407T
A4890	A9563	D7240	G0277	G0427	G9483	0165T	0272T	0408T
A9500	A9564	D7241	G0278	G0429	G9484	0174T	0273T	0409T
A9501	A9566	D7250	G0281	G0438	G9485	0175T	0274T	0410T
A9502	A9567	D7260	G0283	G0439	G9486	0184T	0278T	0411T
A9503	A9568	D7291	G0288	G0442	G9487	0190T	0290T	0412T
A9504	A9569	D7940	G0289	G0443	G9488	0191T	0295T	0413T
A9505	A9570	D9110	G0296	G0444	G9489	0195T	0296T	0414T
A9507	A9571	D9230	G0297	G0445	G9685	0196T	0297T	0415T
A9508	A9572	D9630	G0297	G0446	G9686	0198T	0298T	0416T
A9509	A9580	D9930	G0297	G0447	P3001	0200T	0312T	0417T
A9510	A9600	D9940	G0329	G0451	Q0035	0201T	0313T	0418T
A9512	A9699	D9950	G0339	G0452	Q0035	0202T	0314T	0419T
A9516	D0150	D9951	G0340	G0453	Q0035	0205T	0315T	0420T
A9517	D0240	D9952	G0341	G0454	Q0091	0206T	0316T	0421T
A9521	D0250	G0101	G0365	G0455	Q0092	0207T	0317T	0422T
A9524	D0270	G0106	G0365	G0498	Q3001	0208T	0357T	0424T
A9526	D0272	G0106	G0365	G0501	R0070	0209T	0375T	0425T
A9527	D0274	G0106	G0372	G0506	R0075	0210T	0376T	0426T
A9528	D0460	G0108	G0396	G0513	V5299	0211T	0377T	0427T
A9529	D0502	G0109	G0397	G0514	0042T	0212T	0378T	0428T
A9530	D0999	G0117	G0398	G0515	0054T	0213T	0379T	0429T
A9531	D1510	G0118	G0398	G0516	0055T	0214T	0380T	0430T
A9532	D1515	G0120	G0398	G0517	0058T	0215T	0381T	0431T
A9536	D1520	G0120	G0399	G0518	0071T	0216T	0382T	0432T
A9537	D1525	G0120	G0399	G6001	0072T	0217T	0383T	0433T
A9538	D1550	G0124	G0399	G6001	0075T	0218T	0384T	0434T
A9539	D2999	G0128	G0400	G6001	0075T	0219T	0385T	0435T
A9540	D3460	G0130	G0400	G6002	0075T	0220T	0386T	0436T
A9541	D3999	G0130	G0400	G6002	0076T	0221T	0387T	0437T
A9542	D4260	G0130	G0402	G6002	0076T	0222T	0388T	0439T
A9543	D4263	G0141	G0403	G6003	0076T	0234T	0389T	0440T
A9546	D4264	G0179	G0404	G6004	0095T	0235T	0390T	0441T
A9547	D4270	G0180	G0405	G6005	0098T	0236T	0391T	0442T
A9548	D4273	G0181	G0406	G6006	0100T	0237T	0394T	0443T
A9550	D4355	G0182	G0407	G6007	0101T	0238T	0395T	0444T
A9551	D4381	G0186	G0408	G6008	0102T	0249T	0396T	0445T
A9552	D5911	G0237	G0409	G6009	0106T	0253T	0397T	0483T
A9553	D5912	G0238	G0416	G6010	0107T	0254T	0398T	0484T
A9554	D5951	G0239	G0416	G6011	0108T	0263T	0399T	10021
A9555	D5983	G0245	G0416	G6012	0109T	0264T	0400T	10022
A9556	D5984	G0246	G0420	G6013	0110T	0265T	0401T	10030
A9557	D5985	G0247	G0421	G6014	0126T	0266T	0402T	10035
A9558	D5987	G0248	G0422	G6015	0159T	0267T	0403T	10036
A9559	D6920	G0249	G0423	G6016	0159T	0268T	0404T	11005
A9560	D7210	G0250	G0424	G6017	0159T	0269T	0405T	11008

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
11045	15780	19286	21249	24620	26250	27307	28545	29900
11046	15782	19287	21280	24640	26370	27372	28546	29901
11047	15783	19288	21295	24935	26412	27391	28570	29902
11300	15792	19294	21296	24999	26415	27416	28575	29999
11301	15793	19296	21299	25023	26428	27497	28576	30000
11302	15819	19297	21325	25025	26449	27501	28600	30310
11303	15820	19298	21330	25031	26450	27503	28605	30320
11305	15821	19301	21336	25035	26455	27509	28630	30400
11306	15824	19324	21337	25040	26471	27517	28635	30465
11307	15825	19325	21338	25100	26478	27538	28665	30600
11308	15826	19342	21340	25101	26480	27550	28750	30630
11310	15828	19355	21345	25105	26489	27552	28805	30999
11311	15829	19396	21355	25116	26490	27562	28810	31002
11312	15833	19499	21356	25120	26496	27604	28899	31233
11313	15834	20103	21400	25125	26500	27605	29000	31235
11451	15835	20555	21421	25130	26508	27615	29010	31238
11462	15836	20662	21440	25210	26510	27616	29015	31239
11463	15837	20663	21450	25240	26516	27648	29035	31240
11471	15838	20665	21451	25270	26536	27664	29040	31241
11755	15839	20680	21452	25272	26540	27825	29044	31287
11920	15860	20910	21453	25274	26542	27830	29046	31288
11921	15876	20912	21454	25275	26545	27831	29049	31290
11922	15877	20939	21485	25280	26548	27860	29055	31291
11950	15878	20950	21497	25624	26567	27882	29058	31292
11951	15879	20985	21499	25635	26591	27892	29305	31293
11952	15920	20999	21510	25651	26607	27893	29325	31294
11954	15933	21010	21899	25660	26608	27899	29520	31297
11971	15941	21029	22010	25675	26641	28041	29581	31298
11976	15944	21046	22999	25680	26645	28045	29584	31299
11981	15945	21048	23146	25690	26670	28054	29710	31510
11982	15951	21050	23330	25900	26675	28055	29750	31512
11983	15999	21070	23333	25920	26705	28080	29799	31513
12017	17108	21073	23520	25927	26715	28088	29800	31520
12037	17380	21076	23525	25999	26756	28113	29838	31527
12046	17999	21077	23545	26025	26841	28261	29840	31528
12056	19081	21081	23575	26030	26850	28280	29846	31529
14350	19082	21082	23935	26035	26991	28307	29850	31531
15002	19083	21083	24000	26037	26992	28309	29866	31551
15003	19084	21084	24120	26060	27025	28345	29867	31552
15004	19085	21085	24200	26100	27027	28405	29868	31553
15005	19086	21086	24220	26105	27050	28406	29874	31554
15600	19112	21087	24305	26135	27057	28435	29875	31560
15610	19281	21088	24310	26170	27086	28455	29877	31561
15650	19282	21100	24357	26180	27175	28476	29879	31572
15731	19283	21181	24358	26200	27198	28525	29880	31573
15775	19284	21208	24359	26230	27256	28530	29881	31574
15776	19285	21230	24495	26235	27257	28540	29883	31577

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
31578	33957	36592	38550	41830	44364	50557	52277	56441
31580	33958	36593	38794	41850	44365	50561	52300	56442
31584	33959	36598	38999	41870	44369	50570	52301	57000
31587	33962	36660	40527	41872	44370	50572	52345	57010
31591	33963	36680	40650	41874	44376	50574	52346	57020
31592	33964	37182	40652	41899	44377	50576	52649	57022
31599	33965	37183	40700	42000	44378	50580	52700	57023
31612	33966	37195	40720	42160	44379	50686	53025	57156
31626	33967	37215	40804	42180	44500	50951	53040	57170
31627	33969	37217	40805	42182	45150	50953	53220	57400
31800	33984	37218	40806	42280	45307	50955	53460	57415
31820	33985	37221	40818	42281	45500	50957	53855	57700
31825	33986	37222	40819	42305	45900	50961	53860	58110
31830	33987	37223	40830	42310	45990	50970	53899	58301
31899	33988	37224	40831	42320	45999	50972	54000	58321
32552	33989	37225	40842	42340	46030	50974	54015	58322
32601	34839	37226	40845	42408	46070	50976	54150	58323
32604	35400	37227	40899	42450	46258	50980	54240	58555
32606	35682	37228	41005	42500	46707	51030	54240	58561
32607	35683	37229	41006	42509	46754	51065	54240	58563
32608	36005	37230	41007	42600	46930	51715	54250	58970
32609	36299	37231	41008	42660	46942	51725	54250	59012
32701	36420	37232	41009	42665	46999	51725	54250	59015
33011	36440	37233	41010	42720	47701	51725	54500	59020
33214	36450	37234	41015	42820	48400	51727	54505	59020
33223	36456	37235	41016	42821	49411	51727	54640	59020
33236	36468	37236	41017	42825	49412	51727	54660	59025
33237	36510	37237	41018	42830	49418	51728	54670	59025
33238	36557	37238	41019	42831	49423	51728	54800	59025
33340	36558	37239	41114	42835	49424	51728	54830	59030
33361	36560	37252	41115	42836	49427	51729	54861	59050
33362	36561	37253	41250	42842	49440	51729	54865	59051
33363	36563	37565	41251	42860	49441	51729	54900	59130
33364	36565	37790	41252	42870	49442	51736	54901	59135
33365	36566	37799	41500	42900	49446	51736	55060	59160
33366	36570	38200	41510	42960	49450	51736	55120	59300
33367	36571	38205	41512	42999	49451	51785	55175	59320
33368	36575	38206	41520	43246	49452	51785	55180	59325
33369	36576	38220	41530	43273	49460	51785	55200	59409
33477	36578	38221	41599	43420	49465	51792	55300	59412
33503	36581	38222	41805	43999	50385	51792	55500	59414
33951	36582	38230	41806	44132	50386	51792	55600	59425
33952	36583	38232	41820	44133	50387	51797	55605	59426
33953	36585	38240	41821	44135	50396	51797	55680	59610
33954	36589	38241	41822	44136	50430	51797	55875	59612
33955	36590	38242	41823	44312	50551	51798	55899	59614
33956	36591	38243	41828	44363	50555	51999	55920	59618

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
59622	64569	68330	70130	70320	70481	70547	71100	72050
59821	64570	68340	70130	70328	70481	70547	71101	72050
59830	64605	68399	70130	70328	70482	70547	71101	72052
59840	64611	68510	70134	70328	70482	70548	71101	72052
59841	64630	68520	70134	70330	70482	70548	71110	72052
59850	64632	68761	70134	70330	70486	70548	71110	72070
59851	64650	68770	70140	70330	70486	70549	71110	72070
59852	64653	68899	70140	70332	70486	70549	71111	72070
59855	64718	69140	70140	70332	70487	70549	71111	72072
59856	64734	69300	70150	70332	70487	70551	71111	72072
59857	64744	69399	70150	70336	70487	70551	71120	72072
59871	64776	69450	70150	70336	70488	70551	71120	72074
60000	64784	69502	70160	70336	70488	70552	71120	72074
61050	64787	69505	70160	70350	70488	70552	71130	72074
61105	64790	69511	70160	70350	70490	70552	71130	72080
61120	64832	69601	70170	70350	70490	70553	71130	72080
61645	64834	69602	70170	70355	70490	70553	71250	72080
61710	64999	69603	70170	70355	70491	70553	71250	72081
61781	65091	69636	70190	70355	70491	70554	71250	72081
61782	65150	69637	70190	70360	70491	70554	71260	72081
61783	65235	69646	70190	70360	70492	70554	71260	72082
61791	65270	69661	70200	70360	70492	70555	71260	72082
61885	65275	69666	70200	70370	70492	70555	71270	72082
61886	65280	69667	70200	70370	70496	70555	71270	72083
62165	65410	69720	70210	70370	70496	70557	71270	72083
62194	65757	69799	70210	70371	70496	70557	71275	72083
62252	65778	69801	70210	70371	70498	70557	71275	72084
62252	65779	69910	70220	70371	70498	70558	71275	72084
62252	65820	69930	70220	70380	70498	70558	71550	72084
62267	65860	69949	70220	70380	70540	70558	71550	72100
62269	66130	69979	70240	70380	70540	70559	71550	72100
62292	66700	70010	70240	70390	70540	70559	71551	72100
62355	66825	70015	70240	70390	70542	70559	71551	72110
62360	66852	70015	70250	70390	70542	71045	71551	72110
62361	66920	70015	70250	70450	70542	71045	71552	72110
62362	66930	70030	70250	70450	70543	71045	71552	72114
62365	66940	70030	70260	70450	70543	71046	71552	72114
63600	66999	70030	70260	70460	70543	71046	71555	72114
63610	67299	70100	70260	70460	70544	71046	71555	72120
63746	67316	70100	70300	70460	70544	71047	71555	72120
64408	67346	70100	70300	70470	70544	71047	72020	72120
64410	67415	70110	70300	70470	70545	71047	72020	72125
64455	67560	70110	70310	70470	70545	71048	72020	72125
64508	67835	70110	70310	70480	70545	71048	72040	72125
64553	67961	70120	70310	70480	70546	71048	72040	72126
64566	67999	70120	70320	70480	70546	71100	72040	72126
64568	68328	70120	70320	70481	70546	71100	72050	72126

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
72127	72158	72255	73090	73222	73580	73719	74182	74260
72127	72159	72265	73090	73222	73580	73720	74182	74260
72127	72159	72265	73092	73222	73580	73720	74183	74260
72128	72170	72265	73092	73223	73590	73720	74183	74261
72128	72170	72270	73092	73223	73590	73721	74183	74261
72128	72170	72270	73100	73223	73590	73721	74185	74261
72129	72190	72270	73100	73225	73592	73721	74185	74262
72129	72190	72275	73100	73225	73592	73722	74185	74262
72129	72190	72275	73110	73501	73592	73722	74190	74262
72130	72191	72275	73110	73501	73600	73722	74190	74270
72130	72191	72285	73110	73501	73600	73723	74190	74270
72130	72191	72285	73115	73502	73600	73723	74210	74270
72131	72192	72285	73115	73502	73610	73723	74210	74280
72131	72192	72295	73115	73502	73610	73725	74210	74280
72131	72192	72295	73120	73503	73610	73725	74220	74280
72132	72193	72295	73120	73503	73615	73725	74220	74283
72132	72193	73000	73120	73503	73615	74018	74220	74283
72132	72193	73000	73130	73521	73615	74018	74230	74283
72133	72194	73000	73130	73521	73620	74018	74230	74290
72133	72194	73010	73130	73521	73620	74019	74230	74290
72133	72194	73010	73140	73522	73620	74019	74235	74290
72141	72195	73010	73140	73522	73630	74019	74235	74300
72141	72195	73020	73140	73522	73630	74021	74235	74300
72141	72195	73020	73200	73523	73630	74021	74240	74300
72142	72196	73020	73200	73523	73650	74021	74240	74301
72142	72196	73030	73200	73523	73650	74022	74240	74301
72142	72196	73030	73201	73525	73650	74022	74241	74301
72146	72197	73030	73201	73525	73660	74022	74241	74328
72146	72197	73040	73201	73525	73660	74150	74241	74328
72146	72197	73040	73202	73551	73660	74150	74245	74328
72147	72198	73040	73202	73551	73700	74150	74245	74329
72147	72198	73050	73202	73551	73700	74160	74245	74329
72147	72198	73050	73206	73552	73700	74160	74246	74329
72148	72200	73050	73206	73552	73701	74160	74246	74330
72148	72200	73060	73206	73552	73701	74170	74246	74330
72148	72200	73060	73218	73560	73701	74170	74247	74330
72149	72202	73060	73218	73560	73702	74170	74247	74340
72149	72202	73070	73218	73560	73702	74174	74247	74340
72149	72202	73070	73219	73562	73702	74174	74249	74340
72156	72220	73070	73219	73562	73706	74174	74249	74355
72156	72220	73080	73219	73562	73706	74175	74249	74355
72156	72220	73080	73220	73564	73706	74175	74250	74355
72157	72240	73080	73220	73564	73718	74175	74250	74360
72157	72240	73085	73220	73564	73718	74181	74250	74360
72157	72240	73085	73221	73565	73718	74181	74251	74360
72158	72255	73085	73221	73565	73719	74181	74251	74363
72158	72255	73090	73221	73565	73719	74182	74251	74363

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
74363	74740	75635	75805	75885	76000	76498	76705	76817
74400	74740	75635	75807	75885	76000	76499	76705	76817
74400	74742	75635	75807	75887	76000	76499	76706	76817
74400	74742	75705	75807	75887	76001	76499	76706	76818
74410	74742	75705	75809	75887	76001	76506	76706	76818
74410	74775	75705	75809	75889	76001	76506	76770	76818
74410	74775	75710	75809	75889	76010	76506	76770	76819
74415	74775	75710	75810	75889	76010	76510	76770	76819
74415	75557	75710	75810	75891	76010	76510	76775	76819
74415	75557	75716	75810	75891	76080	76510	76775	76820
74420	75557	75716	75820	75891	76080	76511	76775	76820
74420	75559	75716	75820	75893	76080	76511	76776	76820
74420	75559	75726	75820	75893	76098	76511	76776	76821
74425	75559	75726	75822	75893	76098	76512	76776	76821
74425	75561	75726	75822	75894	76098	76512	76800	76821
74425	75561	75731	75822	75894	76100	76512	76800	76825
74430	75561	75731	75825	75894	76100	76513	76800	76825
74430	75563	75731	75825	75898	76100	76513	76801	76825
74430	75563	75733	75825	75898	76101	76513	76801	76826
74440	75563	75733	75827	75898	76101	76514	76801	76826
74440	75565	75733	75827	75901	76101	76514	76802	76826
74440	75565	75736	75827	75901	76102	76514	76802	76827
74445	75565	75736	75831	75901	76102	76516	76802	76827
74445	75571	75736	75831	75902	76102	76516	76805	76827
74445	75571	75741	75831	75902	76120	76516	76805	76828
74450	75571	75741	75833	75902	76120	76519	76805	76828
74450	75572	75741	75833	75956	76120	76519	76810	76828
74450	75572	75743	75833	75956	76125	76519	76810	76830
74455	75572	75743	75840	75956	76125	76529	76810	76830
74455	75573	75743	75840	75957	76125	76529	76811	76830
74455	75573	75746	75840	75957	76376	76529	76811	76831
74470	75573	75746	75842	75957	76376	76536	76811	76831
74470	75574	75746	75842	75958	76376	76536	76812	76831
74470	75574	75756	75842	75958	76377	76536	76812	76856
74485	75574	75756	75860	75958	76377	76604	76812	76856
74485	75600	75756	75860	75959	76377	76604	76813	76856
74485	75600	75774	75860	75959	76380	76604	76813	76857
74710	75600	75774	75870	75959	76380	76641	76813	76857
74710	75605	75774	75870	75970	76380	76641	76814	76857
74710	75605	75801	75870	75970	76496	76641	76814	76870
74712	75605	75801	75872	75970	76496	76642	76814	76870
74712	75625	75801	75872	75984	76496	76642	76815	76870
74712	75625	75803	75872	75984	76497	76642	76815	76872
74713	75625	75803	75880	75984	76497	76700	76815	76872
74713	75630	75803	75880	75989	76497	76700	76816	76872
74713	75630	75805	75880	75989	76498	76700	76816	76873
74740	75630	75805	75885	75989	76498	76705	76816	76873

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
76873	76970	77075	77299	77387	77762	78020	78135	78232
76881	76970	77075	77300	77399	77763	78020	78140	78232
76881	76975	77075	77300	77399	77763	78020	78140	78258
76881	76975	77076	77300	77399	77763	78070	78140	78258
76882	76975	77076	77301	77401	77767	78070	78185	78258
76882	76977	77076	77301	77402	77767	78070	78185	78261
76882	76977	77077	77301	77407	77767	78071	78185	78261
76885	76977	77077	77306	77412	77768	78071	78191	78261
76885	76998	77077	77306	77417	77768	78071	78191	78262
76885	76998	77078	77306	77423	77768	78072	78191	78262
76886	76998	77078	77307	77431	77770	78072	78195	78262
76886	76999	77078	77307	77432	77770	78072	78195	78264
76886	76999	77080	77307	77435	77770	78075	78195	78264
76930	76999	77080	77316	77469	77771	78075	78199	78264
76930	77001	77080	77316	77470	77771	78075	78199	78265
76930	77001	77081	77316	77470	77771	78099	78199	78265
76932	77001	77081	77317	77470	77772	78099	78201	78265
76932	77002	77081	77317	77499	77772	78099	78201	78266
76932	77002	77084	77317	77499	77772	78102	78201	78266
76936	77002	77084	77318	77499	77778	78102	78202	78266
76936	77003	77084	77318	77520	77778	78102	78202	78270
76936	77003	77085	77318	77522	77778	78103	78202	78270
76937	77003	77085	77321	77523	77789	78103	78205	78270
76937	77013	77085	77321	77525	77789	78103	78205	78271
76937	77013	77086	77321	77600	77789	78104	78205	78271
76940	77013	77086	77331	77600	77790	78104	78206	78271
76940	77022	77086	77331	77600	77799	78104	78206	78272
76940	77022	77261	77331	77605	77799	78110	78206	78272
76941	77065	77262	77332	77605	77799	78110	78215	78272
76941	77065	77263	77332	77605	78012	78110	78215	78278
76941	77065	77280	77332	77610	78012	78111	78215	78278
76942	77066	77280	77333	77610	78012	78111	78216	78278
76942	77066	77280	77333	77610	78013	78111	78216	78282
76942	77066	77285	77333	77615	78013	78120	78216	78282
76945	77067	77285	77334	77615	78013	78120	78226	78282
76945	77067	77285	77334	77615	78014	78120	78226	78290
76945	77067	77290	77334	77620	78014	78121	78226	78290
76946	77071	77290	77336	77620	78014	78121	78227	78290
76946	77072	77290	77338	77620	78015	78121	78227	78291
76946	77072	77293	77338	77750	78015	78122	78227	78291
76948	77072	77293	77338	77750	78015	78122	78230	78291
76948	77073	77293	77370	77750	78016	78122	78230	78299
76948	77073	77295	77371	77761	78016	78130	78230	78299
76965	77073	77295	77372	77761	78016	78130	78231	78299
76965	77074	77295	77373	77761	78018	78130	78231	78300
76965	77074	77299	77385	77762	78018	78135	78231	78300
76970	77074	77299	77386	77762	78018	78135	78232	78300

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
78305	78466	78598	78700	78804	79440	88108	88300	88334
78305	78468	78598	78700	78805	79440	88112	88302	88334
78305	78468	78599	78700	78805	79440	88112	88302	88341
78306	78468	78599	78701	78805	79445	88112	88302	88341
78306	78469	78599	78701	78806	79445	88120	88304	88341
78306	78469	78600	78701	78806	79445	88120	88304	88342
78315	78469	78600	78707	78806	79999	88120	88304	88342
78315	78472	78600	78707	78807	79999	88121	88305	88342
78315	78472	78601	78707	78807	79999	88121	88305	88344
78320	78472	78601	78708	78807	80500	88121	88305	88344
78320	78473	78601	78708	78808	80502	88125	88307	88344
78320	78473	78605	78708	78811	83020	88125	88307	88346
78399	78473	78605	78709	78811	84165	88125	88307	88346
78399	78481	78605	78709	78811	84166	88141	88309	88346
78399	78481	78606	78709	78812	84181	88160	88309	88348
78414	78481	78606	78710	78812	84182	88160	88309	88348
78414	78483	78606	78710	78812	85060	88160	88311	88348
78414	78483	78607	78710	78813	85097	88161	88311	88350
78428	78483	78607	78725	78813	85390	88161	88311	88350
78428	78491	78607	78725	78813	85396	88161	88312	88350
78428	78491	78608	78725	78814	85576	88162	88312	88355
78445	78491	78608	78730	78814	86077	88162	88312	88355
78445	78492	78608	78730	78814	86078	88162	88313	88355
78445	78492	78610	78730	78815	86079	88172	88313	88356
78451	78492	78610	78740	78815	86153	88172	88313	88356
78451	78494	78610	78740	78815	86255	88172	88314	88356
78451	78494	78630	78740	78816	86256	88173	88314	88358
78452	78494	78630	78761	78816	86320	88173	88314	88358
78452	78496	78630	78761	78816	86325	88173	88319	88358
78452	78496	78635	78761	78999	86327	88177	88319	88360
78453	78496	78635	78799	78999	86334	88177	88319	88360
78453	78499	78635	78799	78999	86335	88177	88321	88360
78453	78499	78645	78799	79005	86485	88182	88323	88361
78454	78499	78645	78800	79005	86486	88182	88323	88361
78454	78579	78645	78800	79005	86490	88182	88323	88361
78454	78579	78647	78800	79101	86510	88184	88325	88362
78457	78579	78647	78801	79101	86580	88185	88329	88362
78457	78580	78647	78801	79101	87164	88187	88331	88362
78457	78580	78650	78801	79200	87207	88188	88331	88363
78458	78580	78650	78802	79200	88104	88189	88331	88364
78458	78582	78650	78802	79200	88104	88199	88332	88364
78458	78582	78660	78802	79300	88104	88199	88332	88364
78459	78582	78660	78803	79300	88106	88199	88332	88365
78459	78597	78660	78803	79300	88106	88291	88333	88365
78459	78597	78699	78803	79403	88106	88299	88333	88365
78466	78597	78699	78804	79403	88108	88300	88333	88366
78466	78598	78699	78804	79403	88108	88300	88334	88366

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
88366	90474	91020	91133	92145	92311	92546	92610	93017
88367	90839	91020	91200	92145	92312	92547	92611	93018
88367	90840	91022	91200	92145	92313	92548	92612	93024
88367	90845	91022	91200	92225	92315	92548	92613	93024
88368	90846	91022	91299	92226	92316	92548	92614	93024
88368	90847	91030	91299	92227	92317	92550	92615	93025
88368	90849	91030	91299	92228	92325	92552	92616	93025
88369	90853	91030	92002	92228	92326	92553	92617	93025
88369	90865	91034	92004	92228	92499	92555	92620	93040
88369	90870	91034	92012	92230	92499	92556	92621	93041
88371	90880	91034	92014	92235	92499	92557	92625	93042
88372	90899	91035	92018	92235	92502	92561	92626	93050
88373	90901	91035	92019	92235	92504	92562	92627	93050
88373	90911	91035	92020	92240	92507	92563	92640	93050
88373	90935	91037	92025	92240	92508	92564	92700	93224
88374	90937	91037	92025	92240	92511	92565	92920	93225
88374	90945	91037	92025	92242	92512	92567	92924	93226
88374	90947	91038	92060	92242	92516	92568	92928	93227
88375	90951	91038	92060	92242	92520	92570	92933	93228
88377	90952	91038	92060	92250	92521	92571	92937	93229
88377	90953	91040	92065	92250	92522	92572	92941	93260
88377	90954	91040	92065	92250	92523	92575	92943	93260
88380	90955	91040	92065	92260	92524	92576	92950	93260
88380	90956	91065	92071	92265	92526	92577	92953	93261
88380	90957	91065	92072	92265	92537	92579	92960	93261
88381	90958	91065	92081	92265	92537	92582	92970	93261
88381	90959	91110	92081	92270	92537	92583	92971	93268
88381	90960	91110	92081	92270	92538	92584	92973	93270
88387	90961	91110	92082	92270	92538	92585	92974	93271
88387	90962	91111	92082	92275	92538	92585	92975	93272
88387	90963	91111	92082	92275	92540	92585	92977	93278
88388	90964	91111	92083	92275	92540	92586	92978	93278
88388	90965	91112	92083	92283	92540	92587	92978	93278
88388	90966	91112	92083	92283	92541	92587	92978	93279
88399	90967	91112	92100	92283	92541	92587	92979	93279
88399	90968	91117	92132	92284	92541	92588	92979	93279
88399	90969	91120	92132	92284	92542	92588	92979	93280
89049	90970	91120	92132	92284	92542	92588	92986	93280
89060	90997	91120	92133	92285	92542	92596	92987	93280
89220	90999	91122	92133	92285	92544	92597	92990	93281
89230	91010	91122	92133	92285	92544	92601	92997	93281
89240	91010	91122	92134	92286	92544	92602	92998	93281
90460	91010	91132	92134	92286	92545	92603	93000	93282
90461	91013	91132	92134	92286	92545	92604	93005	93282
90471	91013	91132	92136	92287	92545	92607	93010	93282
90472	91013	91133	92136	92287	92546	92608	93015	93283
90473	91020	91133	92136	92287	92546	92609	93016	93283

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
93283	93307	93454	93562	93619	93702	93923	94004	94640
93284	93307	93455	93562	93619	93724	93923	94010	94642
93284	93308	93455	93563	93619	93724	93924	94010	94644
93284	93308	93455	93564	93620	93724	93924	94010	94645
93285	93308	93456	93565	93620	93745	93924	94011	94660
93285	93312	93456	93566	93620	93745	93925	94012	94662
93285	93312	93456	93567	93621	93745	93925	94013	94664
93286	93312	93457	93568	93621	93750	93925	94014	94667
93286	93313	93457	93571	93621	93784	93926	94015	94668
93286	93314	93457	93571	93622	93786	93926	94016	94669
93287	93314	93458	93571	93622	93788	93926	94060	94680
93287	93314	93458	93572	93622	93790	93930	94060	94680
93287	93315	93458	93572	93623	93792	93930	94060	94680
93288	93315	93459	93572	93623	93793	93930	94070	94681
93288	93315	93459	93580	93623	93797	93931	94070	94681
93288	93316	93459	93581	93624	93798	93931	94070	94681
93289	93317	93460	93582	93624	93799	93931	94200	94690
93289	93317	93460	93583	93624	93799	93970	94200	94690
93289	93317	93460	93591	93631	93799	93970	94200	94690
93290	93318	93461	93600	93631	93880	93970	94250	94726
93290	93318	93461	93600	93631	93880	93971	94250	94726
93290	93318	93461	93600	93640	93880	93971	94250	94726
93291	93320	93462	93602	93640	93882	93971	94375	94727
93291	93320	93463	93602	93640	93882	93975	94375	94727
93291	93320	93464	93602	93641	93882	93975	94375	94727
93292	93321	93464	93603	93641	93886	93975	94400	94728
93292	93321	93464	93603	93641	93886	93976	94400	94728
93292	93321	93503	93603	93642	93886	93976	94400	94728
93293	93325	93505	93609	93642	93888	93976	94450	94729
93293	93325	93505	93609	93642	93888	93978	94450	94729
93293	93325	93505	93609	93644	93888	93978	94450	94729
93294	93350	93530	93610	93644	93890	93978	94452	94750
93295	93350	93530	93610	93644	93890	93979	94452	94750
93296	93350	93530	93610	93650	93890	93979	94452	94750
93297	93352	93531	93612	93653	93892	93979	94453	94760
93298	93355	93531	93612	93654	93892	93980	94453	94761
93299	93451	93531	93612	93655	93892	93980	94453	94762
93303	93451	93532	93613	93656	93893	93980	94610	94770
93303	93451	93532	93615	93657	93893	93981	94617	94772
93303	93452	93532	93615	93660	93893	93981	94617	94772
93304	93452	93533	93615	93660	93895	93981	94617	94772
93304	93452	93533	93616	93660	93895	93990	94618	94774
93304	93453	93533	93616	93662	93895	93990	94618	94775
93306	93453	93561	93616	93662	93922	93990	94618	94776
93306	93453	93561	93618	93662	93922	93998	94621	94777
93306	93454	93561	93618	93668	93922	94002	94621	94799
93307	93454	93562	93618	93701	93923	94003	94621	94799

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
94799	95805	95851	95885	95926	95956	96105	96549	97535
95004	95805	95852	95886	95926	95957	96111	96567	97537
95012	95805	95857	95886	95927	95957	96116	96573	97542
95017	95806	95860	95886	95927	95957	96118	96574	97545
95018	95806	95860	95887	95927	95958	96119	96900	97546
95024	95806	95860	95887	95928	95958	96120	96904	97597
95027	95807	95861	95887	95928	95958	96125	96910	97598
95028	95807	95861	95905	95928	95961	96127	96912	97605
95044	95807	95861	95905	95929	95961	96150	96913	97606
95052	95808	95863	95905	95929	95961	96151	96931	97607
95056	95808	95863	95907	95929	95962	96152	96932	97608
95060	95808	95863	95907	95930	95962	96153	96933	97610
95065	95810	95864	95907	95930	95962	96154	96934	97750
95070	95810	95864	95908	95930	95965	96360	96935	97755
95071	95810	95864	95908	95933	95965	96361	96936	97760
95076	95811	95865	95908	95933	95965	96365	96999	97761
95079	95811	95865	95909	95933	95966	96366	97012	97763
95115	95811	95865	95909	95937	95966	96367	97016	97799
95117	95812	95866	95909	95937	95966	96368	97018	97802
95144	95812	95866	95910	95937	95967	96369	97022	97803
95145	95812	95866	95910	95938	95967	96370	97024	97804
95146	95813	95867	95910	95938	95967	96371	97026	98925
95147	95813	95867	95911	95938	95970	96372	97028	98926
95148	95813	95867	95911	95939	95971	96373	97032	98927
95149	95816	95868	95911	95939	95972	96374	97033	98928
95165	95816	95868	95912	95939	95974	96375	97034	98929
95170	95816	95868	95912	95940	95975	96377	97035	98940
95180	95819	95869	95912	95943	95978	96379	97036	98941
95199	95819	95869	95913	95943	95979	96401	97039	98942
95249	95819	95869	95913	95943	95980	96402	97110	99082
95250	95822	95870	95913	95950	95981	96409	97112	99091
95251	95822	95870	95921	95950	95982	96411	97113	99175
95782	95822	95870	95921	95950	95990	96413	97116	99183
95782	95824	95872	95921	95951	95991	96415	97124	99184
95782	95824	95872	95922	95951	95992	96416	97139	99188
95783	95824	95872	95922	95951	95999	96417	97140	99195
95783	95827	95873	95922	95953	96000	96420	97150	99199
95783	95827	95873	95923	95953	96001	96422	97161	99201
95800	95827	95873	95923	95953	96002	96423	97162	99202
95800	95829	95874	95923	95954	96003	96425	97163	99203
95800	95829	95874	95924	95954	96004	96440	97164	99204
95801	95829	95874	95924	95954	96020	96446	97165	99205
95801	95830	95875	95924	95955	96020	96450	97166	99211
95801	95831	95875	95925	95955	96020	96521	97167	99212
95803	95832	95875	95925	95955	96101	96522	97168	99213
95803	95833	95885	95925	95956	96102	96523	97530	99214
95803	95834	95885	95926	95956	96103	96542	97533	99215

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
99217	99344	99498						
99218	99345	99499						
99219	99347							
99220	99348							
99221	99349							
99222	99350							
99223	99354							
99224	99355							
99225	99356							
99226	99357							
99231	99358							
99232	99359							
99233	99406							
99234	99407							
99235	99415							
99236	99416							
99238	99455							
99239	99456							
99281	99460							
99282	99461							
99283	99462							
99284	99463							
99285	99464							
99291	99465							
99292	99466							
99304	99467							
99305	99468							
99306	99469							
99307	99471							
99308	99472							
99309	99475							
99310	99476							
99315	99477							
99316	99478							
99318	99479							
99324	99480							
99325	99483							
99326	99484							
99327	99487							
99328	99489							
99334	99490							
99335	99492							
99336	99493							
99337	99494							
99341	99495							
99342	99496							
99343	99497							

APPENDIX L3
LIST OF PAYABLE MEDICARE FIRST ASSIST CODES

The following is a list of procedure codes for which there is no statutory payment restriction for assistants at surgery. Assistant at surgery may be paid.

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
G0276	20100	21139	21344	21743	22595	22902	23472	24342
G0342	20150	21141	21347	21750	22600	22903	23473	24343
G0343	20251	21142	21348	21811	22610	22904	23474	24344
G0412	20692	21143	21360	21812	22612	22905	23485	24345
G0413	20696	21145	21365	21813	22614	23000	23490	24346
G0414	20697	21146	21366	21825	22630	23020	23491	24360
G0415	20802	21147	21385	21931	22632	23035	23515	24361
0494T	20805	21150	21386	21932	22633	23040	23530	24362
12018	20808	21151	21387	21933	22634	23071	23532	24363
12047	20816	21154	21390	21936	22800	23073	23550	24365
12057	20822	21155	21395	22100	22802	23077	23552	24366
14301	20824	21159	21401	22101	22804	23078	23585	24370
14302	20827	21160	21406	22102	22808	23100	23615	24371
15734	20838	21172	21407	22103	22810	23105	23616	24400
15738	20900	21175	21408	22110	22812	23107	23630	24410
15750	20902	21179	21422	22112	22818	23120	23660	24420
15756	20922	21180	21423	22114	22819	23125	23670	24430
15757	20924	21182	21431	22116	22830	23145	23680	24435
15758	20937	21183	21432	22206	22840	23150	23800	24470
15770	20938	21184	21433	22207	22842	23155	23802	24498
15830	20955	21188	21435	22208	22843	23156	23900	24515
15832	20956	21193	21436	22210	22844	23172	23920	24516
15841	20957	21194	21445	22212	22845	23174	23929	24545
15842	20962	21195	21462	22214	22846	23182	24006	24546
15845	20969	21196	21465	22216	22847	23184	24071	24575
15847	20970	21198	21470	22220	22848	23190	24073	24579
15922	20972	21199	21490	22222	22849	23195	24079	24586
15935	20973	21206	21502	22224	22850	23200	24100	24587
15952	20975	21209	21552	22226	22852	23210	24101	24615
19260	21011	21240	21554	22318	22853	23220	24102	24635
19271	21012	21242	21557	22319	22854	23395	24115	24665
19272	21013	21243	21558	22325	22855	23397	24116	24666
19302	21014	21244	21600	22326	22856	23400	24125	24685
19303	21016	21245	21610	22327	22857	23405	24126	24800
19304	21034	21246	21615	22328	22858	23406	24134	24802
19305	21044	21247	21616	22532	22859	23410	24138	24900
19306	21045	21255	21620	22533	22861	23412	24140	24920
19307	21047	21256	21627	22534	22862	23420	24149	24925
19316	21049	21260	21630	22548	22864	23430	24150	24930
19318	21060	21261	21632	22551	22865	23440	24152	24931
19357	21121	21263	21685	22552	22867	23450	24155	24940
19361	21122	21267	21700	22554	22868	23455	24301	25071
19364	21123	21268	21705	22556	22869	23460	24320	25073
19366	21125	21270	21720	22558	22870	23462	24330	25078
19367	21127	21275	21725	22585	22899	23465	24331	25085
19368	21137	21339	21740	22586	22900	23466	24340	25107
19369	21138	21343	21742	22590	22901	23470	24341	25119

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
25126	25491	26483	27049	27226	27381	27488	27691	28118
25135	25492	26485	27052	27227	27385	27495	27692	28122
25136	25515	26492	27054	27228	27386	27498	27698	28130
25145	25525	26494	27059	27236	27390	27499	27700	28171
25151	25526	26497	27065	27244	27392	27506	27702	28202
25170	25545	26498	27066	27245	27393	27507	27703	28210
25215	25574	26499	27067	27248	27394	27511	27705	28238
25250	25575	26502	27070	27253	27395	27513	27709	28250
25251	25607	26517	27071	27254	27396	27514	27712	28260
25263	25608	26518	27075	27258	27397	27519	27715	28262
25265	25609	26530	27076	27259	27400	27524	27720	28264
25300	25628	26531	27077	27267	27403	27535	27722	28289
25301	25645	26541	27078	27268	27405	27536	27724	28291
25310	25670	26546	27080	27269	27407	27540	27725	28292
25312	25676	26550	27087	27279	27409	27556	27727	28295
25315	25685	26551	27090	27280	27412	27557	27740	28296
25316	25695	26553	27091	27282	27415	27558	27742	28297
25320	25800	26554	27097	27284	27418	27566	27745	28298
25332	25805	26555	27098	27286	27420	27580	27756	28299
25335	25810	26556	27100	27290	27422	27590	27758	28300
25350	25820	26560	27105	27295	27424	27591	27759	28302
25355	25825	26561	27110	27299	27427	27592	27814	28304
25360	25830	26562	27111	27303	27428	27598	27822	28305
25365	25905	26565	27120	27305	27429	27599	27823	28306
25370	25907	26568	27122	27306	27430	27602	27826	28308
25375	25909	26580	27125	27310	27435	27612	27827	28320
25390	25915	26587	27130	27325	27438	27620	27828	28322
25391	25922	26590	27132	27326	27440	27625	27829	28360
25392	25924	26596	27134	27329	27441	27626	27832	28415
25393	25929	26686	27137	27331	27442	27632	27846	28420
25394	26111	26820	27138	27332	27443	27634	27848	28445
25400	26113	26842	27140	27333	27445	27637	27870	28446
25405	26118	26843	27146	27334	27446	27638	27871	28555
25415	26185	26844	27147	27335	27447	27645	27880	28585
25420	26260	26852	27151	27337	27448	27646	27881	28615
25425	26262	26862	27156	27339	27450	27647	27888	28705
25426	26352	26863	27158	27345	27454	27650	27894	28715
25431	26357	27001	27161	27347	27455	27654	28039	28725
25440	26358	27003	27165	27350	27457	27656	28047	28730
25441	26372	27005	27170	27355	27465	27658	28086	28735
25442	26373	27006	27176	27356	27466	27659	28100	28737
25443	26390	27030	27177	27357	27468	27665	28102	28740
25444	26392	27033	27178	27358	27470	27675	28103	28760
25446	26420	27035	27179	27360	27472	27676	28104	28800
25447	26434	27036	27181	27364	27479	27685	28106	29804
25449	26474	27045	27187	27365	27486	27687	28107	29820
25490	26479	27048	27202	27380	27487	27690	28114	29821

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
29822	30460	32096	32662	33261	33504	33677	33824	33991
29823	30462	32097	32663	33265	33505	33681	33840	33992
29824	30540	32098	32664	33266	33506	33684	33845	33993
29825	30545	32100	32665	33300	33507	33688	33851	33999
29826	31075	32110	32666	33305	33508	33690	33852	34001
29827	31080	32120	32667	33310	33510	33692	33853	34051
29828	31081	32124	32668	33315	33511	33694	33860	34101
29834	31084	32140	32669	33320	33512	33697	33863	34111
29835	31085	32141	32670	33321	33513	33702	33864	34151
29836	31086	32150	32671	33322	33514	33710	33870	34201
29837	31087	32151	32672	33330	33516	33720	33875	34203
29843	31205	32160	32673	33335	33517	33722	33877	34401
29844	31225	32200	32674	33390	33518	33724	33880	34421
29845	31230	32215	32800	33391	33519	33726	33881	34451
29847	31295	32220	32810	33404	33521	33730	33883	34501
29851	31296	32225	32815	33405	33522	33732	33884	34502
29855	31300	32310	32820	33406	33523	33735	33886	34510
29856	31360	32320	32851	33410	33530	33736	33889	34520
29860	31365	32440	32852	33411	33533	33737	33891	34530
29861	31367	32442	32853	33412	33534	33750	33910	34701
29862	31368	32445	32854	33413	33535	33755	33915	34702
29863	31370	32480	32855	33414	33536	33762	33916	34703
29884	31375	32482	32856	33415	33542	33764	33917	34704
29885	31380	32484	32900	33416	33545	33766	33920	34705
29887	31382	32486	32905	33417	33548	33767	33922	34706
29888	31390	32488	32906	33418	33572	33768	33924	34707
29889	31395	32491	32940	33419	33600	33770	33925	34708
29891	31400	32501	32994	33422	33602	33771	33926	34709
29892	31420	32503	32998	33425	33606	33774	33927	34710
29894	31590	32504	33020	33426	33608	33775	33928	34711
29895	31595	32505	33025	33427	33610	33776	33929	34712
29897	31601	32506	33030	33430	33611	33777	33933	34713
29898	31611	32507	33031	33460	33612	33778	33935	34714
29899	31634	32540	33050	33463	33615	33779	33944	34715
29904	31750	32553	33120	33464	33617	33780	33945	34716
29905	31755	32561	33130	33465	33619	33781	33970	34808
29906	31760	32562	33140	33468	33620	33782	33973	34812
29907	31766	32650	33141	33470	33621	33783	33975	34813
29914	31770	32651	33243	33471	33622	33786	33976	34820
29915	31775	32652	33250	33474	33641	33788	33977	34830
29916	31780	32653	33251	33475	33645	33800	33978	34831
30125	31781	32654	33254	33476	33647	33802	33979	34832
30160	31785	32655	33255	33478	33660	33803	33980	34833
30410	31786	32656	33256	33496	33665	33813	33981	34834
30430	31805	32658	33257	33500	33670	33814	33982	34841
30435	32035	32659	33258	33501	33675	33820	33983	34842
30450	32036	32661	33259	33502	33676	33822	33990	34843

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
34844	35261	35558	35701	38102	40843	43030	43340	43773
34845	35266	35560	35721	38115	40844	43045	43341	43774
34846	35271	35563	35741	38120	41120	43100	43351	43775
34847	35276	35565	35761	38129	41130	43101	43352	43800
34848	35281	35566	35800	38308	41135	43107	43360	43810
35001	35286	35570	35820	38380	41140	43108	43361	43820
35002	35301	35571	35840	38381	41145	43112	43400	43825
35005	35302	35572	35860	38382	41150	43113	43401	43830
35011	35303	35583	35870	38530	41153	43116	43405	43831
35013	35304	35585	35876	38542	41155	43117	43410	43832
35021	35305	35587	35879	38555	42120	43118	43415	43840
35022	35306	35600	35881	38562	42200	43121	43425	43843
35045	35311	35601	35883	38564	42205	43122	43496	43845
35081	35321	35606	35884	38570	42210	43123	43500	43846
35082	35331	35612	35901	38571	42215	43124	43501	43847
35091	35341	35616	35903	38572	42220	43130	43502	43848
35092	35351	35621	35905	38573	42225	43135	43510	43850
35102	35355	35623	35907	38589	42226	43279	43520	43855
35103	35361	35626	36261	38700	42227	43280	43605	43860
35111	35363	35631	36460	38720	42235	43281	43610	43865
35112	35371	35632	36818	38724	42260	43282	43611	43870
35121	35372	35633	36819	38740	42299	43283	43620	43880
35122	35390	35634	36820	38745	42409	43284	43621	43881
35131	35500	35636	36821	38746	42410	43285	43622	43882
35132	35501	35637	36825	38747	42415	43286	43631	43886
35141	35506	35638	36830	38760	42420	43287	43632	43887
35142	35508	35642	36831	38765	42425	43288	43633	43888
35151	35509	35645	36832	38770	42426	43289	43634	44005
35152	35510	35646	36833	38780	42440	43300	43635	44010
35180	35511	35647	36838	38900	42507	43305	43640	44015
35182	35512	35650	37145	39000	42510	43310	43641	44020
35184	35515	35654	37160	39010	42699	43312	43644	44021
35188	35516	35656	37180	39200	42725	43313	43645	44025
35189	35518	35661	37181	39220	42810	43314	43647	44050
35190	35521	35663	37600	39499	42815	43320	43648	44055
35201	35522	35665	37605	39501	42844	43325	43651	44110
35206	35523	35666	37606	39503	42845	43327	43652	44111
35211	35525	35671	37615	39540	42890	43328	43653	44120
35216	35526	35681	37616	39541	42892	43330	43659	44121
35221	35531	35685	37617	39545	42894	43331	43753	44125
35226	35533	35686	37618	39560	42950	43332	43754	44126
35231	35535	35691	37619	39561	42953	43333	43755	44127
35236	35536	35693	37660	39599	42955	43334	43756	44128
35241	35537	35694	37761	40701	42961	43335	43757	44130
35246	35538	35695	37788	40702	42971	43336	43770	44137
35251	35539	35697	38100	40799	42972	43337	43771	44139
35256	35556	35700	38101	40840	43020	43338	43772	44140

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
44141	44650	45800	47400	48500	49540	50225	50725	51595
44143	44660	45805	47420	48510	49550	50230	50727	51596
44144	44661	45820	47425	48520	49553	50234	50728	51597
44145	44680	45825	47460	48540	49555	50236	50740	51800
44146	44700	46705	47480	48545	49557	50240	50750	51820
44147	44701	46710	47550	48547	49560	50250	50760	51840
44150	44715	46712	47562	48548	49561	50280	50770	51841
44151	44720	46715	47563	48551	49565	50290	50780	51845
44155	44721	46716	47564	48552	49566	50320	50782	51860
44156	44800	46730	47570	48554	49568	50323	50783	51865
44157	44820	46735	47579	48556	49570	50325	50785	51880
44158	44850	46740	47600	48999	49572	50327	50800	51900
44160	44899	46742	47605	49000	49580	50328	50810	51920
44180	44900	46744	47610	49002	49582	50329	50815	51925
44186	44950	46746	47612	49010	49585	50340	50820	51940
44187	44955	46748	47620	49020	49587	50360	50825	51960
44188	44960	46750	47700	49040	49590	50365	50830	51980
44202	44970	46751	47711	49062	49600	50370	50840	51990
44203	44979	46760	47712	49203	49605	50380	50845	51992
44204	45110	46761	47715	49204	49606	50400	50860	53085
44205	45111	46762	47720	49205	49610	50405	50900	53210
44206	45112	47010	47721	49215	49611	50500	50920	53215
44207	45113	47015	47740	49220	49650	50520	50930	53230
44208	45114	47100	47741	49255	49651	50525	50940	53235
44210	45116	47120	47760	49320	49652	50526	50945	53400
44211	45119	47122	47765	49321	49653	50540	50947	53405
44212	45120	47125	47780	49322	49654	50541	50948	53410
44213	45121	47130	47785	49323	49655	50542	50949	53415
44227	45123	47135	47800	49324	49656	50543	51020	53425
44238	45126	47140	47801	49325	49657	50544	51040	53430
44300	45130	47141	47802	49326	49659	50545	51045	53431
44310	45135	47142	47900	49327	49900	50546	51050	53440
44314	45136	47143	48000	49329	49905	50547	51060	53442
44316	45160	47144	48001	49425	50010	50548	51080	53444
44320	45171	47145	48020	49435	50045	50549	51500	53445
44322	45172	47146	48100	49436	50060	50562	51520	53446
44345	45395	47147	48105	49491	50065	50593	51525	53447
44346	45397	47300	48120	49492	50070	50600	51530	53448
44602	45400	47350	48140	49495	50075	50605	51535	53449
44603	45402	47360	48145	49496	50081	50610	51550	53500
44604	45499	47361	48146	49500	50100	50620	51555	53505
44605	45540	47362	48148	49501	50120	50630	51565	53510
44615	45541	47370	48150	49505	50125	50650	51570	53515
44620	45550	47371	48152	49507	50130	50660	51575	54110
44625	45560	47379	48153	49520	50135	50700	51580	54111
44626	45562	47380	48154	49521	50205	50715	51585	54112
44640	45563	47381	48155	49525	50220	50722	51590	54115

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
54120	55150	57240	58240	58673	59899	61343	61582	61860
54125	55400	57250	58260	58674	60200	61345	61583	61863
54130	55520	57260	58262	58679	60210	61450	61584	61864
54135	55535	57265	58263	58700	60212	61458	61585	61867
54205	55550	57267	58267	58720	60220	61460	61586	61868
54300	55559	57268	58270	58740	60225	61480	61590	61870
54304	55650	57270	58275	58750	60240	61500	61591	61880
54308	55706	57280	58280	58752	60252	61501	61592	62005
54312	55720	57282	58285	58760	60254	61510	61596	62010
54316	55725	57283	58290	58770	60260	61512	61597	62100
54318	55801	57284	58291	58805	60270	61514	61598	62115
54322	55810	57285	58292	58820	60271	61516	61600	62117
54324	55812	57287	58293	58822	60280	61518	61601	62120
54326	55815	57288	58294	58825	60281	61519	61605	62121
54328	55821	57289	58345	58900	60500	61520	61606	62140
54332	55831	57291	58356	58920	60502	61521	61607	62141
54336	55840	57292	58400	58925	60505	61522	61608	62142
54340	55842	57295	58410	58940	60512	61524	61610	62143
54344	55845	57296	58520	58943	60520	61531	61611	62145
54348	55862	57300	58540	58950	60521	61533	61612	62146
54352	55865	57305	58541	58951	60522	61534	61613	62147
54360	55866	57307	58542	58952	60540	61535	61615	62161
54380	56620	57308	58543	58953	60545	61536	61616	62162
54385	56625	57310	58544	58954	60600	61537	61618	62163
54390	56630	57311	58545	58956	60605	61538	61619	62164
54405	56631	57320	58546	58957	60650	61539	61630	62180
54406	56632	57330	58548	58958	60659	61540	61635	62192
54408	56633	57335	58550	58960	60699	61541	61680	62200
54410	56634	57423	58552	58974	61140	61543	61682	62220
54411	56637	57425	58553	58976	61154	61544	61684	62223
54415	56640	57426	58554	59070	61156	61545	61686	62230
54416	56700	57530	58560	59074	61250	61546	61690	62256
54417	56800	57531	58570	59076	61253	61548	61692	62258
54420	56805	57540	58571	59100	61304	61550	61697	62351
54430	56810	57545	58572	59120	61305	61552	61698	62380
54437	57106	57550	58573	59121	61312	61556	61700	63001
54438	57107	57555	58575	59136	61313	61557	61702	63003
54440	57109	57556	58578	59140	61314	61558	61703	63005
54522	57110	57720	58579	59150	61315	61559	61705	63011
54530	57111	58140	58600	59151	61320	61563	61708	63012
54535	57112	58145	58605	59350	61321	61564	61711	63015
54550	57120	58146	58611	59514	61322	61566	61796	63016
54560	57130	58150	58615	59525	61323	61567	61797	63017
54650	57200	58152	58660	59620	61330	61570	61798	63020
54680	57210	58180	58661	59866	61332	61571	61799	63030
54690	57220	58200	58662	59870	61333	61575	61800	63035
54699	57230	58210	58672	59898	61340	61576	61850	63040

CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS	CPT/HCPCS
63042	63265	63744	64874	67040	93592			
63043	63266	64490	64876	67041				
63044	63267	64491	64885	67042				
63045	63268	64492	64886	67043				
63046	63270	64493	64890	67107				
63047	63271	64494	64891	67108				
63048	63272	64495	64892	67113				
63050	63273	64580	64893	67121				
63051	63275	64704	64895	67255				
63055	63276	64708	64896	67340				
63056	63277	64712	64897	67399				
63057	63278	64713	64898	67413				
63064	63280	64714	64901	67414				
63066	63281	64716	64902	67420				
63075	63282	64722	64905	67430				
63076	63283	64732	64907	67440				
63077	63285	64736	64910	67445				
63078	63286	64738	64911	67450				
63081	63287	64740	64912	67570				
63082	63290	64742	64913	67599				
63085	63295	64746	65105	67973				
63086	63300	64755	65110	67974				
63087	63301	64760	65112	68720				
63088	63302	64763	65114	68745				
63090	63303	64766	65260	68750				
63091	63304	64771	65265	69155				
63101	63305	64772	65710	69320				
63102	63306	64786	65730	69530				
63103	63307	64792	65750	69550				
63170	63308	64802	65755	69552				
63172	63620	64804	65756	69554				
63173	63621	64809	65770	69605				
63180	63655	64818	65781	69670				
63182	63661	64835	65900	69711				
63185	63662	64836	66170	69725				
63190	63663	64837	66172	69740				
63191	63664	64840	66174	69745				
63194	63685	64857	66175	69805				
63195	63700	64858	66179	69915				
63196	63702	64859	66180	69950				
63197	63704	64861	66183	69955				
63198	63706	64862	66184	69960				
63199	63707	64864	66185	69970				
63200	63709	64865	66220	69990				
63250	63710	64866	67027	92992				
63251	63740	64868	67036	92993				
63252	63741	64872	67039	93590				

APPENDIX M
AMBULATORY SURGICAL CENTERS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Ambulatory Surgical Center Fee Schedule

PAYMENT SYSTEM FACT SHEET SERIES

ICN 006819 April 2014

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on the Ambulatory Surgical Center Fee Schedule (ASCFS):

- The definition of an ASC;
- ASC payment;
- How payment rates are determined;
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program; and
- Resources.

When "you" is used in this publication, we are referring to ASCs.

Definition of an Ambulatory Surgical Center (ASC)

An ASC, for Medicare purposes, is a distinct entity that operates exclusively for the purpose of furnishing surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission. This definition applies to the ASC, no matter who the payor is for the ASC's services. Additionally, as discussed in the Ambulatory Surgical Center Payment section on page 3, services are not expected to require active medical monitoring at midnight when furnished in an ASC.

You must be certified as meeting the requirements for an ASC and enter into an agreement with the Centers for Medicare & Medicaid Services (CMS) to be eligible for Medicare payment. An ASC can be either:

- Independent (not part of a provider of services or any other facility); or
- Operated by a hospital (under the common ownership, licensure, or control of a hospital). An ASC operated by a hospital must:
  - Be a separately identifiable entity separately enrolled in Medicare, with a supplier approval that is distinct from the hospital's Medicare provider agreement; is physically, administratively, and financially independent and distinct from other operations of the hospital; and costs for the ASC are treated as a non-reimbursable cost center on the hospital's cost report;
  - Agree to the same assignment, coverage, and payment rules applied to independent ASCs; and
  - Comply with the conditions for coverage for ASCs.

An ASC operated by a hospital is not the same as a provider-based outpatient surgery department of a hospital. A provider-based outpatient department of a hospital, including an outpatient surgery department:

- May be on- or off-campus;
- Must be an integral part of the hospital, subject to the hospital conditions of participation; and
- Is not separately enrolled and certified in Medicare or subject to ASC conditions for coverage.

Ambulatory Surgical Center (ASC) Payment

Effective January 1, 2008, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, CMS implemented a revised ASC payment system using the Outpatient Prospective Payment System (OPPS) relative payment weights as a guide. The policies for the revised ASC payment system were made in the ASC final rule (CMS-1517-F), which was published in the "Federal Register" on August 2, 2007. The ASC final rule greatly expanded the types of procedures eligible for payment in the ASC setting and excluded from eligibility only those procedures that pose a significant safety risk to patients or are expected to require active medical monitoring at midnight when furnished in an ASC. The rule also provided a 4-year transition to the fully implemented revised ASC payment rates. Beginning with the November 2007 OPPS/ASC final rule with comment period (CMS-1392-FC), the annual update OPPS/ASC final rule with comment period provides the ASC payment rates and lists the surgical procedures and services that qualify for separate payment under the revised ASC payment system.

Medicare makes a single payment to ASCs for covered surgical procedures, which includes ASC facility services furnished in connection with the covered procedure. Examples of covered ASC facility services paid through the payment for covered surgical procedures include:

- Nursing services, services furnished by technical personnel, and other related services;
- Patient use of ASC facilities;
- Drugs and biologicals for which separate payment is not made under the OPPS, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies;
- Materials for anesthesia;
- Intraocular lenses;
- Implantable devices, with the exception of those devices with pass-through status under the OPPS; and
- Radiology services for which payment is packaged under the OPPS.

You are also separately paid for covered ancillary services integral to a covered surgical procedure that you bill, specifically certain services furnished immediately before, during, or immediately after the covered surgical procedure. Covered ancillary services include:

- Drugs and biologicals separately paid under the OPPS;
- Radiology services separately paid under the OPPS;
- Brachytherapy sources;
- Implantable devices with OPPS pass-through status; and
- Corneal tissue acquisition.

Certain services may be furnished in ASCs and billed by the appropriate certified provider or supplier. The chart on page 4 provides examples of payment and billing for items or services that are not included in ASC payments for covered surgical procedures or covered ancillary services.

Examples of Items and Services Not Included in ASC Payments for Covered Surgical Procedures or Covered Ancillary Services

Items or Services Not Included	Who Receives Payment	Where to Submit Bills
Physicians' Services	Physician	Medicare Administrative Contractor (MAC)
Purchase or Rental of Non-Implantable Durable Medical Equipment (DME) to ASC Patients for Use in Their Homes	DME supplier A supplier of DME must have a DME supplier number from the National Supplier Clearinghouse (NSC) and a separate National Provider Identifier (NPI) An ASC may not simultaneously be a DME supplier	Durable Medical Equipment Medicare Administrative Contractor (DME MAC)
Non-Implantable Prosthetic devices	DME supplier A supplier of DME must have a DME supplier number from the NSC and a separate NPI An ASC may not simultaneously be a DME supplier	DME MAC
Ambulance Services	Certified ambulance supplier	MAC
Leg, Arm, Back, and Neck Braces	DME supplier	DME MAC
Artificial Legs, Arms, and Eyes	DME supplier	DME MAC
Services Furnished by Independent Laboratory	Certified laboratory (ASC can receive laboratory certification and a Clinical Laboratory Improvement Amendments number)	MAC
Facility Services for Surgical Procedures Excluded From the ASC List (listed in Addendum EE to the OPPS/ASC final rule with comment period)	Not covered by Medicare	Patient is liable

The patient coinsurance for ASC-covered surgical procedures and covered ancillary services is 20 percent of the Medicare ASC payment after the yearly Part B deductible has been met. Section 4104 of the Affordable Care Act waives the coinsurance and deductible for certain preventive services paid under the ASC payment system and recommended by the United States (U.S.) Preventive Services Task Force with a grade of A or B.

How Payment Rates Are Determined

In the annual updates to the ASC payment system, CMS sets **relative payment weights** equal to OPPS relative payment weights for the same services and then scales the ASC weights to maintain budget neutrality from year to year, as mandated by the MMA. For calendar year (CY) 2014, the ASC relative payment weights are scaled to eliminate any difference in the total payment weight between CYs 2013 and 2014.

The relative payment weights for CY 2014 are scaled by:

- Holding ASC utilization and mix of services constant from CY 2012 (the most recent full year of claims data available); and
- Comparing the total payment weight using the CY 2013 ASC relative payment weights to the total payment weight using the applicable CY 2014 OPPS relative payment weights for covered ASC surgical procedures and separately payable ancillary services.

This process takes into account the changes in the relative payment weights between CYs 2013 and 2014.

The ratio of the CY 2013 to CY 2014 total payment weight is the **weight scaler**, which is applied to the CY 2014 relative payment weights to maintain budget neutrality.

The ASC **conversion factor** (CF) is annually adjusted for budget neutrality by removing the effects of changes in wage index values for the upcoming year as compared to values for the current year. In accordance with the MMA, beginning with CY 2010, the ASC CF may be updated annually by the Consumer Price Index for All Urban Consumers. As required by the Affordable Care Act, the annual update factor for the ASC payment system is reduced by a productivity adjustment.

You are paid the lesser of the actual charge or the ASC payment rate for each procedure or service. The standard payment rate for ASC-covered surgical procedures is calculated as the product of the ASC CF and the ASC relative payment weight for each separately payable procedure or service.

Alternate methods are used to establish payments for office-based procedures, device-intensive procedures, covered ancillary radiology services, and drugs and biologicals. Payments for covered surgical procedures and certain covered ancillary services are geographically adjusted using the pre-floor and pre-reclassified hospital wage index values, with a labor-related factor of 50 percent. Payments are also adjusted when multiple surgical procedures are furnished in the same encounter or when procedures are discontinued prior to their initiation or the administration of anesthesia.

The alternate methods to establish payment rates for some surgical procedures and ancillary services are briefly described below:

- Office-based procedures furnished in physicians' offices at least 50 percent of the time and CMS classifies as "office-based" – Payment is made at the lower of the ASC rate or the nonfacility practice expense (PE) relative value unit (RVU) amount of the Medicare Physician Fee Schedule (PFS) for the relevant year;
- Device-intensive procedures, which are ASC-covered surgical procedures that, under the OPPS, are assigned to ambulatory payment classifications (APC) for which the estimated device offset percentage is greater than 50 percent of the APC's mean cost – Payment consists of:
  - A device-related portion of the procedure, which is the same amount paid for the device under the OPPS; and
  - A service portion, which is calculated according to the standard rate setting methodology;
- Separately payable facility costs of covered ancillary radiology services – Payment is made at the lower of the ASC rate or the technical component or nonfacility PE RVU payment amount of the Medicare PFS for the same year (whichever applies);
- Separately payable drugs and biologicals under the OPPS – Payment is made at the same amount paid under the OPPS; and
- Brachytherapy sources – Payment is made at the same amount as OPPS rates if a prospective OPPS rate is available. Otherwise, you are paid at contractor-priced rates. These payments are not adjusted for geographic wage differences.

Under the revised ASC payment system, you should continue to submit claims on the CMS-1500 claim form.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

ASCs must meet all ASCQR Program requirements to receive the full ASC annual program update. Requirements include the submission of complete data on individual quality measures using appropriate Quality Data Codes on Medicare claims. The first payment determinations under the program affecting CY 2014 payment have been made. For more information about ASCQR Program requirements, visit https://www.qualitynet.org on the QualityNet website.

Resources

The chart below provides ASCFS resource information.

Ambulatory Surgical Center Fee Schedule Resources

For More Information About…	Resource
Ambulatory Surgical Centers	http://www.cms.gov/Center/Provider-Type/Ambulatory-Surgical-Centers-ASC-Center.html on the CMS website
Ambulatory Surgical Center Fee Schedule	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment on the CMS website Chapter 14 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf on the CMS website
Interpretive Guidelines for Medicare Certification Standards	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html on the CMS website
Payment Related to Annual and Quarterly Ambulatory Surgical Center Fee Schedule and Drug File Addenda	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website
The "Federal Register"	http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR on the U.S. Government Printing Office website
All Available Medicare Learning Network® (MLN) Products	"Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right

Ambulatory Surgical Center Fee Schedule Resources (cont.)

For More Information About…	Resource
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	http://www.medicare.gov on the CMS website

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Official Information Health Care Professionals Can Trust

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APPENDIX N
CMS POLICY ON NFS AND SNFS

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-15-NH

DATE: **March 8, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

This memorandum replaces Survey and Certification memorandum S&C-04-08 dated November 13, 2003, which discusses physician delegation of tasks in SNFs and NFs.

Memorandum Summary

- **Guidance revision:** This memo provides clarification of Federal guidance related to physician delegation of certain tasks in SNFs and NFs to non-physician practitioners (NPPs; formerly "physician extenders") such as nurse practitioners, physician assistants, or clinical nurse specialists
- **Implements Section 3108 of the Affordable Care Act (ACA):** Implements section 3108 of the Affordable Care Act, which adds physician assistants to the list of practitioners that can perform Skilled Nursing Facility (SNF) level of care certifications and re-certifications.
- **Co-signing of orders:** Clarifies policy on co-signing orders in SNFs and NFs.

A. Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying for State survey agencies and providers the regulatory differences concerning physician delegation of tasks in SNFs and NFs. The distinction in policies between these two settings (SNFs and NFs) is based in statute and regulation. Improper application of these regulations may affect a facility's compliance and may also affect payment to providers. The key to accurate application is to identify:

(1) in which setting, SNF or NF, the physician services are being provided;
(2) whether the task must be performed personally by the physician; and
(3) whether or not the non-physician practitioner (NPP) is employed by the facility.

The "setting" is determined by whether the visit to a patient in a certified bed is to a resident whose care is paid for by Medicare Part A in a SNF or under Medicaid in a NF. This memorandum addresses the authority of NPPs (i.e., nurse practitioners, physician assistants, or

clinical nurse specialists) to perform certain tasks such as conducting physician visits and writing orders, and to sign certifications and re-certifications.

B. Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs)

Under the requirements for long-term care facilities, 42 C.F.R. §483.40(e)(2) provides that, "A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies."

Physician Required and other Medically Necessary Visits in SNFs: Under 42 C.F.R. §483.40(c)(3), all required physician visits must be made by the physician personally and cannot be delegated. A required physician visit includes the initial comprehensive visit in a SNF and every alternate required visit thereafter, as required in 42 C.F.R. §483.40(c)(4). The initial comprehensive visit in a SNF is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident. Under 42 C.F.R. §483.40(c)(1), the initial comprehensive visit must occur no later than 30 days after a resident's admission into the SNF. Further, under 42 C.F.R. §483.40(c)(4) and (e), the physician may not delegate the initial comprehensive visit in a SNF. Non-physician practitioners may perform other medically necessary visits prior to and after the physician's initial comprehensive visit.

Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) who is licensed as such by the State and performing within the scope of practice in that State, as permitted under 42 C.F.R. §483.40(c)(4). These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP (physician co-signature is not required).

Certifications/Re-certifications in SNFs: Under 42 C.F.R. §424.20, certifications and re-certifications are required to verify that a resident requires daily skilled nursing care or rehabilitation services. Section 424.20(e)(2) (which reflects the requirements of section 1814 (a)(2) of the Social Security Act (Act)) states that NPs and CNSs who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under the scope of practice for the State. Effective with services furnished on or after January 1, 2011, Section 1814(a)(2) of the Act, which was amended by section 3108 of the Affordable Care Act, authorizes physician assistants who are not employed by the facility to perform the required initial certification and periodic re-certifications of a beneficiary's need for a SNF level of care.

C. Performance of Physician Tasks in Nursing Facilities (NFs)

Physician Required and Other Medically Necessary Visits in NFs: Similar to a SNF, the initial comprehensive visit in a NF is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident, which must take place no later than 30 days after admission. Section 483.40(f) provides that "At the

option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician." In other words, NPPs that have a direct relationship with a physician and who are not employed by the facility may perform the initial comprehensive visit, any other required physician visit, and other medically necessary visits for a resident of a NF as the State allows. NPPs may also perform other medically necessary visits prior to and after the physician initial comprehensive visit.

At the option of the State, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under the schedule prescribed at 42 C.F.R. §483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits. For example, if a resident complains of a headache, the NP, CNS, or PA employed by the NF may assess the resident and write orders to address the condition. The physician is not required, other than by State law as applicable, to verify and sign orders written by NPPs who are employed by the facility for other medically necessary visits. These medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 C.F.R. §483.40(c)(1).

In contrast to the initial SNF visit, NPPs may provide initial NF visits and other required visits under 42 C.F.R. §§483.40(c)(3) and (f) if the State permits it. Under these regulations, required physician tasks, such as verifying and signing orders in an NF, may be delegated to a PA, NP, or CNS who is **not** an employee of the facility but who is working in collaboration with a physician. Orders written by an NPP who is employed by the NF and are written during visits that are not required visits, and are therefore "other medically necessary visits," do not require physician co-signature except as mandated by State law.

We are issuing this clarification because, where a NPP is permitted to perform a medically necessary visit, the NPP is likewise permitted to write applicable orders during that visit. The Federal requirements restricting NPPs who are employed by the NF from performing a *required visit*, do not apply to *other medically necessary visits*. Thus, this guidance clarifies when an NPP employed by a NF may write orders without a countersignature unless State law requires it.

NOTE: Regulatory language is included for reference purposes:

> **§483.40(f) Performance of Physician Tasks in NFs**
> **At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.**

D. Dually-Certified Facilities (SNF/NFs)

While the regulations do not address dually-certified SNF/NFs directly, the law is clear about who can perform tasks in a SNF and in a NF. In a facility where beds are dually–certified under

Medicare and Medicaid, the facility must determine how the particular resident stay is being paid. For residents in a Part A Medicare stay, the NPP must follow the guidelines for services in a SNF. For residents in a Medicaid stay, the NPP must follow the provisions outlined for care in NFs. As such, in a dually-certified nursing home, any required physician task for a Medicaid beneficiary in a Medicaid stay certified bed, at the option of the State, may be performed by a NPP who is not an employee of the facility but who is working in collaboration with a physician. In addition, in a dually-certified nursing home and at the option of a physician, required physician visits for a Medicare beneficiary in a Part A Medicare stay certified bed may be alternated between personal visits by the physician and visits by a NPP after the physician makes the initial first visit.

Table 1 below summarizes the requirements for non-physician practitioners to perform visits, sign orders, and sign certifications and re-certifications, when this function is permitted under the scope of practice for the State.

Table 1: Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certifications/Re-certifications When Permitted by the State*

	Initial Comprehensive Visit /Orders	**Other Required Visits^**	**Other Medically Necessary Visits & Orders+**	**Certification/ Recertification**
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable ±
PA, NP, & CNS not a facility employee	May perform/ May sign	May perform	May perform and sign	Not applicable ±

*This reflects clinical practice guidelines

^Other required visits are the required monthly visits.

+Medically necessary visits may be performed prior to the initial comprehensive visit.

± This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

For questions on this memorandum, please contact Alice Bonner at alice.bonner@cms.hhs.gov.

Effective Date: This policy is in effect immediately.

Training: This policy should be shared with all appropriate survey and certification staff, their managers, and the state/regional office training coordinator.

APPENDIX O
Diagnostic Procedures by Supervision Level

Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-01-28 **Date: APRIL 19, 2001**

CHANGE REQUEST 850

SUBJECT: Physician Supervision of Diagnostic Tests

BACKGROUND

This Program Memorandum (PM) sets forth revised levels of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule. Section 410.32(b) of the Code of Federal Regulations, as adopted in the Medicare physician fee schedule final rule of October 31, 1997, requires that diagnostic tests covered under §1861(s)(3) of the Social Security 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 Social Security Act) to be considered reasonable and necessary and, therefore, covered under Medicare. The regulation defines these levels of physician supervision for diagnostic tests as follows:

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

The preamble to the final rule of October 31, 1997 assigned a level of physician supervision to most diagnostic tests payable under the physician fee schedule. Implementation of the levels set forth in the final rule was delayed by a memorandum to the HCFA regional offices dated January 28, 1998. The list provides the required level of physician supervision for tests performed under the provisions of 42 CFR 410.32(b).

Effective July 1, 2001, certain codes in the range of CPT 95860 through 95937 will have new supervision levels (either 21, 22, 6a, 66, 77 or 77a). This implementation date will make it possible for physical therapists to acquire the certification required to perform these services without supervision.

Carriers should place the information on your websites immediately and include this information in your next regularly scheduled bulletin.

NOTE: Effective July 1, 2001, a physical therapist who is presently certified by the American Board of Physical Therapy Specialties can perform procedures assigned a level of 21, 22, 66, 6a, 77, or 77a without supervision.

LEVELS OF PHYSICIAN SUPERVISION OF DIAGNOSTIC TESTS

1 = Procedure must be performed under the general supervision of a physician.

2 = Procedure must be performed under the direct supervision of a physician.

3 = Procedure must be performed under the personal supervision of a physician.

4 = Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

5 = Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

6 = Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the service under State law.

LEVEL OF PHYSICIAN SUPERVISION OF SPECIFIC DIAGNOSTIC TESTS

CODE	LEVEL	CODE	LEVEL	CODE	LEVEL
URODYNAMICS					
51725 & TC	2	51726 & TC	2	51736 & TC	2
51741 & TC	2	51772 & TC	2	51784 & TC	2
51785 & TC	3	51792 & TC	2	51795 & TC	2
51797 & TC	2				
MALE GENITAL SYSTEM					
54240 & TC	2	54250 & TC	1		
ANTEPARTUM SERVICES					
59020 & TC	2	59025 & TC	1		
RESERVOIR/PUMP IMPLANTATION					
62367 & TC	2	62368 & TC	2		
DIAGNOSTIC RADIOLOGY					
HEAD AND NECK					
70010 & TC	3	70015 & TC	3	70030 & TC	1
70100 & TC	1	70110 & TC	1	70120 & TC	1
70130 & TC	1	70134 & TC	1	70140 & TC	1
70150 & TC	1	70160 & TC	1	70170 & TC	3
70190 & TC	1	70200 & TC	1	70210 & TC	1
70220 & TC	1	70240 & TC	1	70250 & TC	1
70260 & TC	1	70300 & TC	1	70310 & TC	1
70320 & TC	1	70328 & TC	1	70330 & TC	1
70332 & TC	3	70336 & TC	2	70350 & TC	1
70355 & TC	1	70360 & TC	1	70370 & TC	3
70371 & TC	3	70373 & TC	3	70380 & TC	1
70390 & TC	3	70450 & TC	1	70460 & TC	2
70470 & TC	2	70480 & TC	1	70481 & TC	2
70482 & TC	2	70486 & TC	1	70487 & TC	2

70488 & TC	2	70490 & TC	1	70491 & TC	2
70492 & TC	2	70540 & TC	1	70541 & TC	2
70551 & TC	1	70552 & TC	2	70553 & TC	2

CHEST

71010 & TC	1	71015 & TC	1	71020 & TC	1
71021 & TC	1	71022 & TC	1	71023 & TC	3
71030 & TC	1	71034 & TC	3	71035 & TC	1
71036 & TC	3	71040 & TC	3	71060 & TC	3
71090 & TC	3	71100 & TC	1	71101 & TC	1
71110 & TC	1	71111 & TC	1	71120 & TC	1
71130 & TC	1	71250 & TC	1	71260 & TC	2
71270 & TC	2	71550 & TC	1	71555 & TC	2

SPINE AND PELVIS

72010 & TC	1	72020 & TC	1	72040 & TC	1
72050 & TC	1	72052 & TC	1	72069 & TC	1
72070 & TC	1	72072 & TC	1	72074 & TC	1
72080 & TC	1	72090 & TC	1	72100 & TC	1
72110 & TC	1	72114 & TC	1	72120 & TC	1
72125 & TC	1	72126 & TC	2	72127 & TC	2
72128 & TC	1	72129 & TC	2	72130 & TC	2
72131 & TC	1	72132 & TC	2	72133 & TC	2
72141 & TC	1	72142 & TC	2	72146 & TC	1
72147 & TC	2	72148 & TC	1	72149 & TC	2
72156 & TC	2	72157 & TC	2	72158 & TC	2
72170 & TC	1	72190 & TC	1	72192 & TC	1
72193 & TC	2	72194 & TC	2	72196 & TC	1
72200 & TC	1	72202 & TC	1	72220 & TC	1
72240 & TC	3	72255 & TC	3	72265 & TC	3
72270 & TC	3	72285 & TC	3	72295 & TC	3

UPPER EXTREMITIES

73000 & TC	1	73010 & TC	1	73020 & TC	1
73030 & TC	1	73040 & TC	3	73050 & TC	1
73060 & TC	1	73070 & TC	1	73080 & TC	1
73085 & TC	3	73090 & TC	1	73092 & TC	1
73100 & TC	1	73110 & TC	1	73115 & TC	3
73120 & TC	1	73130 & TC	1	73140 & TC	1
73200 & TC	1	73201 & TC	2	73202 & TC	2
73220 & TC	1	73221 & TC	1		

LOWER EXTREMITIES

73500 & TC	1	73510 & TC	1	73520 & TC	1
73525 & TC	3	73530 & TC	3	73540 & TC	1
73550 & TC	1	73560 & TC	1	73562 & TC	1
73564 & TC	1	73565 & TC	1	73580 & TC	3
73590 & TC	1	73592 & TC	1	73600 & TC	1
73610 & TC	1	73615 & TC	3	73620 & TC	1
73630 & TC	1	73650 & TC	1	73660 & TC	1
73700 & TC	1	73701 & TC	2	73702 & TC	2
73720 & TC	1	73721 & TC	1	73725 & TC	2

ABDOMEN

74000 & TC	1	74010 & TC	1	74020 & TC	1
74022 & TC	1	74150 & TC	1	74160 & TC	2

74170 & TC	2	74181 & TC	1	74185 & TC	2
74190 & TC	3				

GASTROINTESTINAL TRACT

74210 & TC	3	74220 & TC	3	74230 & TC	3
74235 & TC	3	74240 & TC	3	74241 & TC	3
74245 & TC	3	74246 & TC	3	74247 & TC	3
74249 & TC	3	74250 & TC	2	74251 & TC	3
74260 & TC	3	74270 & TC	3	74280 & TC	3
74283 & TC	3	74290 & TC	1	74291 & TC	1
74300 & TC	3	74301 & TC	3	74305 & TC	3
74320 & TC	3	74327 & TC	3	74328 & TC	3
74329 & TC	3	74330 & TC	3	74340 & TC	3
74350 & TC	3	74355 & TC	3	74360 & TC	3
74363 & TC	3				

URINARY TRACT

74400 & TC	2	74410 & TC	2	74415 & TC	2
74420 & TC	3	74425 & TC	3	74430 & TC	3
74440 & TC	3	74445 & TC	3	74450 & TC	3
74455 & TC	3	74470 & TC	3	74475 & TC	3
74480 & TC	3	74485 & TC	3		

GYNECOLOGICAL AND OBSTETRICAL

74710 & TC	1	74740 & TC	3	74742 & TC	3
74775 & TC	3				

HEART

75552 & TC	1	75553 & TC	2	75554 & TC	1
75555 & TC	1				

AORTA AND ARTERIES

75600 & TC	3	75605 & TC	3	75625 & TC	3
75630 & TC	3	75650 & TC	3	75658 & TC	3
75660 & TC	3	75662 & TC	3	75665 & TC	3
75671 & TC	3	75676 & TC	3	75680 & TC	3
75685 & TC	3	75705 & TC	3	75710 & TC	3
75716 & TC	3	75722 & TC	3	75724 & TC	3
75726 & TC	3	75731 & TC	3	75733 & TC	3
75736 & TC	3	75741 & TC	3	75743 & TC	3
75746 & TC	3	75756 & TC	3	75774 & TC	3
75790 & TC	3				

VEINS AND LYMPHATICS

75801 & TC	3	75803 & TC	3	75805 & TC	3
75807 & TC	3	75809 & TC	3	75810 & TC	3
75820 & TC	3	75822 & TC	3	75825 & TC	3
75827 & TC	3	75831 & TC	3	75833 & TC	3
75840 & TC	3	75842 & TC	3	75860 & TC	3
75870 & TC	3	75872 & TC	3	75880 & TC	3
75885 & TC	3	75887 & TC	3	75889 & TC	3
75891 & TC	3	75893 & TC	3		

TRANSCATHETER PROCEDURES

75894 & TC	3	75896 & TC	3	75898 & TC	3
75900 & TC	3	75940 & TC	3	75945 & TC	3
75946 & TC	3	75960 & TC	3	75961 & TC	3
75962 & TC	3	75964 & TC	3	75966 & TC	3
75968 & TC	3	75970 & TC	3	75978 & TC	3
75980 & TC	3	75982 & TC	3	75984 & TC	3
75989 & TC	3				

TRANSLUMINAL ATHERECTOMY

75992 & TC	3	75993 & TC	3	75994 & TC	3
75995 & TC	3	75996 & TC	3		

OTHER PROCEDURES

76000 & TC	3	76001 & TC	3	76003 & TC	3
76010 & TC	1	76020 & TC	1	76040 & TC	1
76061 & TC	1	76062 & TC	1	76065 & TC	1
76066 & TC	1	76070 & TC	1	76075 & TC	1
76076 & TC	1	76078 & TC	1	76080 & TC	3
76086 & TC	3	76088 & TC	3	76093 & TC	1
76094 & TC	1	76095 & TC	3	76096 & TC	3
76098 & TC	1	76100 & TC	2	76101 & TC	2
76102 & TC	2	76120 & TC	2	76125 & TC	2
76150	1	76350	2	76355 & TC	3
76360 & TC	3	76365 & TC	3	76370 & TC	2
76375 & TC	1	76380 & TC	1	76400 & TC	1

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

76506 & TC	2	76511 & TC	3	76512 & TC	3
76513 & TC	3	76516 & TC	2	76519 & TC	2
76529 & TC	2	76536 & TC	1		

CHEST

76604 & TC	1	76645 & TC	1

ABDOMEN AND RETROPERITONEUM

76700 & TC	1	76705 & TC	1	76770 & TC	1
76775 & TC	1	76778 & TC	1		

SPINAL CANAL

76800 & TC	2

PELVIS

76805 & TC	2	76810 & TC	2	76815 & TC	2
76816 & TC	1	76818 & TC	1	76825 & TC	2
76826 & TC	1	76827 & TC	1	76828 & TC	1
76830 & TC	1	76831 & TC	3	76856 & TC	1
76857 & TC	1	76870 & TC	1	76872 & TC	1

EXTREMITIES

76880 & TC	1	76885 & TC	2	76886 & TC	1

VASCULAR STUDIES

ULTRASONIC GUIDANCE PROCEDURES

76930 & TC	3	76932 & TC	3	76934 & TC	3
76936 & TC	3	76938 & TC	3	76941 & TC	3
76942 & TC	3	76945 & TC	3	76946 & TC	3
76948 & TC	3	76950 & TC	3	76960 & TC	3
76965 & TC	3				

OTHER PROCEDURES

76970 & TC	1	76975 & TC	3	76977 & TC	1
76986 & TC	3				

RADIATION ONCOLOGY

77417	1

DIAGNOSTIC NUCLEAR MEDICINE

ENDOCRINE SYSTEM

78000 & TC	1	78001 & TC	1	78003 & TC	1
78006 & TC	1	78007 & TC	1	78010 & TC	1
78011 & TC	1	78015 & TC	1	78016 & TC	1
78018 & TC	1	78070 & TC	1	78075 & TC	1

HEMATOPOIETIC, RETICULOENDOTHELIAL, AND LYMPHATIC SYSTEM

78102 & TC	1	78103 & TC	1	78104 & TC	1
78110 & TC	1	78111 & TC	1	78120 & TC	1
78121 & TC	1	78122 & TC	1	78130 & TC	1
78135 & TC	1	78140 & TC	1	78160 & TC	1
78162 & TC	1	78170 & TC	1	78172 & TC	1
78185 & TC	1	78190 & TC	1	78191 & TC	1
78195 & TC	1				

GASTROINTESTINAL SYSTEM

78201 & TC	1	78202 & TC	1	78205 & TC	1
78206 & TC	1	78215 & TC	1	78216 & TC	1
78220 & TC	1	78223 & TC	1	78230 & TC	1
78231 & TC	1	78232 & TC	1	78258 & TC	1
78261 & TC	1	78262 & TC	1	78264 & TC	1
78270 & TC	1	78271 & TC	1	78272 & TC	1
78278 & TC	1	78282 & TC	1	78290 & TC	1
78291 & TC	1				

MUSCULOSKELETAL SYSTEM

78300 & TC	1	78305 & TC	1	78306 & TC	1
78315 & TC	1	78320 & TC	1	78350 & TC	1

CARDIOVASCULAR SYSTEM

78414 & TC	1	78428 & TC	1	78445 & TC	1
78455 & TC	1	78457 & TC	1	78458 & TC	1
78460 & TC	1	78461 & TC	1	78464 & TC	1
78465 & TC	1	78466 & TC	1	78468 & TC	1
78469 & TC	1	78472 & TC`	1	78473 & TC	1
78478 & TC	1	78480 & TC	1	78481 & TC	1
78483 & TC	1	78494 & TC	1	78496 & TC	1

RESPIRATORY SYSTEM

78580 & TC	1	78584 & TC	1	78585 & TC	1
78586 & TC	1	78587 & TC	1	78588 & TC	1
78591 & TC	1	78593 & TC	1	78594 & TC	1
78596 & TC	1				

NERVOUS SYSTEM

78600 & TC	1	78601 & TC	1	78605 & TC	1
78606 & TC	1	78607 & TC	1	78610 & TC	1
78615 & TC	1	78630 & TC	1	78635 & TC	1
78645 & TC	1	78647 & TC	1	78650 & TC	1
78660 & TC	1				

GENITOURINARY SYSTEM

78700 & TC	1	78701 & TC	1	78704 & TC	1
78707 & TC	1	78708 & TC	1	78709 & TC	1
78710 & TC	1	78715 & TC	1	78725 & TC	1
78730 & TC	1	78740 & TC	1	78760 & TC	1
78761 & TC	1				

OTHER DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES

78800 & TC	1	78801 & TC	1	78802 & TC	1
78803 & TC	1	78805 & TC	1	78806 & TC	1
78807 & TC	1	78990	1		

MEDICINE

GASTROINTESTINAL

91000 & TC	3	91010 & TC	3	91011 & TC	3
91012 & TC	3	91020 & TC	3	91030 & TC	3
91032 & TC	3	91033 & TC	3	91052 & TC	3
91055 & TC	3	91060 & TC	3	91065 & TC	1
91122 & TC	3				

SPECIAL OPHTHALMOLOGICAL SERVICES

92060 & TC	1	92065 & TC	1	92081 & TC	1
92082 & TC	1	92083 & TC	1	92135 & TC	1
92235 & TC	2	92240 & TC	2	92250 & TC	1

OTHER SPECIALIZED SERVICES

92265 & TC	3	92270 & TC	3	92275 & TC	3
92283 & TC	1	92284 & TC	1	92285 & TC	2
92286 & TC	3				

VESTIBULAR FUNCTION TESTS WITH RECORDING

92541 & TC	5	92542 & TC	5	92543 & TC	5
92544 & TC	5	92545 & TC	5	92546 & TC	5
92547	5	92548 & TC	5		

AUDIOLOGIC FUNCTION TESTS

92552	5	92553	5	92555	5
92556	5	92557	5	92561	5
92562	5	92563	5	92564	5
92565	5	92567	5	92568	5
92569	5	92571	5	92572	5
92573	5	92575	5	92576	5
92577	5	92579	5	92582	5
92583	5	92584	5	92585 & TC	5
92587 & TC	5	92588 & TC	5	92589	5
92596	5				

CARDIOGRAPHY

93000	1	93005	1	93012	1
93015	2	93016	2	93017	2
93024 & TC	3	93040	1	93041	1
93224	1	93225	1	93226	1
93230	1	93231	1	93232	1
93235	1	93236	1	93268	1
93270	1	93271	1	93278 & TC	1

ECHOCARDIOGRAPHY

93303 & TC	1	93304 & TC	1	93307& TC	1
93308 & TC	1	93312 & TC	3	93313	3
93314	3	93315 & TC	3	93316	3
93317	3	93320 & TC	1	93321 & TC	1
93325 & TC	1	93350 & TC	1		

CARDIAC CATHETERIZATION

93501 & TC	3	93505 & TC	3	93508 & TC	3
93510 & TC	3	93511 & TC	3	93514 & TC	3
93524 & TC	3	93526 & TC	3	93527 & TC	3
93528 & TC	3	93529 & TC	3	93530 & TC	3
93531 & TC	3	93532 & TC	3	93533 & TC	3
93555 & TC	3	93556 & TC	3	93561 & TC	3
93562 & TC	3	93571 & TC	3	93572 & TC	3

INTRACARDIAC ELECTROPHYSIOLOGICAL PROCEDURES

93600 & TC	3	93602 & TC	3	93603 & TC	3
93607 & TC	3	93609 & TC	3	93610 & TC	3
93612 & TC	3	93615 & TC	3	93616 & TC	3
93618 & TC	3	93619 & TC	3	93620 & TC	3
93621 & TC	3	93622 & TC	3	93623 & TC	3
93624 & TC	3	93631 & TC	3	93640 & TC	3
93641 & TC	3	93642 & TC	3	93660 & TC	3

OTHER VASCULAR STUDIES

93720	1	93721	1	93724 & TC	3
93731 & TC	2	93732 & TC	2	93733 & TC	1
93734 & TC	2	93735 & TC	2	93736 & TC	1
93737 & TC	2	93738 & TC	2		
93740 & TC	1	93770 & TC	1		

CEREBROVASCULAR ARTERIAL STUDIES

93875 & TC	1	93880 & TC	1	93882 & TC	1
93886 & TC	1	93888 & TC	1		

EXTREMITY ARTERIAL STUDIES

93922 & TC	1	93923 & TC	1	93924 & TC	1
93925 & TC	1	93926 & TC	1	93930 & TC	1
93931 & TC	1				

EXTREMITY VENOUS STUDIES

93965 & TC	1	93970 & TC	1	93971 & TC	1

VISCERAL AND PENILE VASCULAR STUDIES

93975 & TC	1	93976 & TC	1	93978 & TC	1
93979 & TC	1	93980 & TC	1	93981 & TC	1

EXTREMITY ARTERIAL-VENOUS STUDIES

93990 & TC	1

PULMONARY

94010 & TC	1	94014	1	94015	1
94060 & TC	2	94070 & TC	2		
94200 & TC	1	94240 & TC	1		
94250 & TC	1	94260 & TC	1	94350 & TC	1
94360 & TC	1	94370 & TC	1	94375 & TC	1
94400 & TC	2	94450 & TC	2	94620 & TC	1
94621 & TC	2	94664	2	94665	2
94680 & TC	2	94681 & TC	2	94690 & TC	1
94720 & TC	1	94725 & TC	1	94750 & TC	1
94760	1	94761	1	94762	1
94770 & TC	1	94772 & TC	1		

ALLERGY

95004	2	95024	2	95027	2
95028	2	95044	2	95052	2
95056	2	95060	3	95065	3
95070	3	95071	3		
95078	3				

FOR CERTAIN CODES WITHIN THE RANGE OF CPT 95860 THROUGH 95937, THE FOLLOWING ADDITIONAL CRITERIA APPLY.

NOTE: a All level of supervision standards for the lead number ("6" or "7") apply; in addition, the PT with ABPTS certification may personally supervise another PT but only the PT with ABPTS certification may bill.

66 May be performed only by PTs with ABPTS certification and certification in this specific procedure, or performed personally by the physician.

77 PT with ABPTS certification (TC & PC), or direct supervision of physician (TC & PC), or technician with certification and general supervision of physician (TC only; PC physician) procedure.

22 May be performed by a technician with on-line real-time contact with physician

21 Procedure may be performed by technician with certification and under general supervision of a physician; otherwise under direct supervision of physician. (TC only; PC always physician).

NEUROLOGY AND NEUROMUSCULAR PROCEDURES
SLEEP TESTING

95805 & TC	1	95806 & TC	1	95807 & TC	1
95808 & TC	1	95810 & TC	1	95811 & TC	1
95812 & TC	1	95813 & TC	1	95816 & TC	1
95819 & TC	1	95822 & TC	1	95824 & TC	1
95827 & TC	1	95829 & TC	1	95858 & TC	3
95860 & TC	6a	95861 & TC	6a	95863 & TC	6a
95864 & TC	6a	95867 & TC	6a	95868 & TC	6a
95869 & TC	6a	95870 & TC	6a	95872 & TC	66
95875 & TC	3	95900 & TC	77a	95903 & TC	77a
95904 & TC	77a	95920 & TC	22	95921 & TC	2
95922 & TC	3	95923 & TC	3	95925 & TC	21
95926 & TC	21	95927 & TC	21	95930 & TC	21
95933 & TC	77a	95934 & TC	77a	95936 & TC	77a
59937 & TC	77a	95950 & TC	1	95951 & TC	1
95953 & TC	1	95954 & TC	3	95955 & TC	2
95956 & TC	1	95957 & TC	1	95958 & TC	3
95961 & TC	3	95962 & TC	3		

CENTRAL NERVOUS SYSTEM ASSESSMENT

96100	4	96105	4	96110	4
96111	4	96115	4	96117	4

ALPHA-NUMERICS

G0004	1	G0005	1	G0006	1
G0015	1	G0030 & TC	1	G0031 & TC	1
G0032 & TC	1	G0033 & TC	1	G0034 & TC	1
G0035 & TC	1	G0036 & TC	1	G0037 & TC	1
G0038 & TC	1	G0039 & TC	1	G0040 & TC	1
G0041 & TC	1	G0042 & TC	1	G0043 & TC	1
G0044 & TC	1	G0045 & TC	1	G0046 & TC	1
G0047 & TC	1	G0050 1		G0106 & TC	3
G0125 & TC	1	G0126 & TC	1	G0130 & TC	1
G0131 & TC	1	G0132 & TC	1	G0163 & TC	1
G0164 & TC	1	G0165 & TC	1	M0302 & TC	1
Q0035 & TC	1	V5362	1	V5363	1
V5364	1				

The *effective date* for this Program Memorandum (PM) is July 1, 2001.

The *implementation date* for this PM is July 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2002.

If you have any questions, please contact Paul W. Kim at (410) 786-7410.

APPENDIX P
FACE-TO-FACE ENCOUNTER PRIOR TO DME ORDER

Face-to-Face Encounter Requirement for Certain Durable Medical Equipment

Updated 09/09/15

On November 16, 2012 CMS issued a final rule titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013". This final rule was written to implement the statutory provision at Section 1834(a)(11)(B) of the Social Security Act that established requirements for a face-to-face encounter and written orders prior to delivery for certain items of DME (77 Federal Register 68892). CMS developed a list of DME items subject to the Face-to-Face encounter requirements created by the rule. These requirements may be found in the Code of Federal Regulations 42 CFR § 410.38(g). The list of DME items subject to Face-to-Face Encounter requirements may be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf.

The law originally required a physician to document that a physician, nurse practitioner, physician assistant or clinical nurse specialist had a face-to-face encounter with the patient. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) eliminated the requirement for physicians to document face-to-face encounters conducted by allowed nurse practitioners, physician assistants, or clinical nurse specialists. As revised by MACRA, a physician, nurse practitioner, physician assistant or clinical nurse specialist must document they have written the order for DME pursuant to a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

CMS will not start actively enforcing or expect full compliance with the DME face-to-face requirements until further notice. The delay of enforcement only applies to the face-to-face requirements in CFR §410.38(g)(3). CMS expects full compliance with the remaining portions of the regulation. The DME Medicare Administrative Contractors (MACs) began enforcing the detailed written order requirement as of January 1, 2014. The delay in enforcement on the face-to-face encounter requirements applies to reviews conducted by the DME MACs, Recovery Auditors, the Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs). The delay in enforcement does not apply to reviews completed by the Comprehensive Error Rate Testing Program (CERT). CERT must review claims in accordance with all Medicare policies to produce an unbiased improper payment rate.

CMS will continue to address industry questions concerning the new requirements and will update information on our web site at www.cms.gov/medical-review. CMS and its contractors will also use other communication channels to ensure that the provider and supplier community is properly informed of this announcement.

Downloads

DME List of Specified Covered Items – Updated March 26, 2015 [PDF, 69KB]
MLN Matters: Detailed Written Orders and Face-to-Face Encounters [PDF, 108KB]

Page last Modified: 09/10/2015 3:50 PM
Help with File Formats and Plug-Ins

APPENDIX Q
DIABETES SELF-MANAGEMENT TRAINING SERVICES

Relatively few claims for routine-type care are anticipated considering the severity of conditions contemplated as the basis for this exception. Claims for this type of foot care should not be paid in the absence of convincing evidence that nonprofessional performance of the service would have been hazardous for the beneficiary because of an underlying systemic disease. The mere statement of a diagnosis such as those mentioned in §D above does not of itself indicate the severity of the condition. Where development is indicated to verify diagnosis and/or severity the carrier should follow existing claims processing practices, which may include review of carrier's history and medical consultation as well as physician contacts.

The rules in §290.F concerning presumption of coverage also apply.

Codes and policies for routine foot care and supportive devices for the feet are not exclusively for the use of podiatrists. These codes must be used to report foot care services regardless of the specialty of the physician who furnishes the services. Carriers must instruct physicians to use the most appropriate code available when billing for routine foot care.

300 - Diabetes Self-Management Training Services

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);

- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and

- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician.

When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

NOTE: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

300.1 - Beneficiaries Eligible for Coverage and Definition of Diabetes

(Rev. 13, 05-13-04)

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes.

Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria;

- a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;

- a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or

- a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Documentation that the beneficiary is diabetic is maintained in the beneficiary's medical record.

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they have been certified as requiring initial training or they may receive follow-up training when ordered even if Medicare does not have documentation that initial training has been received. In that instance, contractors shall not deny the follow-up service even though there is no initial training recorded.

300.2 - Certified Providers

(Rev. 109; Issued: 08-07-09; Effective Date: 03-30-09; Implementation Date: 09-08-09)

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to the

contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. The CMS is designating all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement.

The CMS will not reimburse services on a fee-for-service basis rendered to a beneficiary under Part A.

NOTE: While separate payment is not made for this service to Rural Health Clinics (RHCs), the service is covered but is considered included in the all-inclusive encounter rate. Effective January 1, 2006, payment for DSMT provided in a Federally Qualified Health Clinic (FQHC) that meets all of the requirements identified in Pub. 100-04, chapter 18, section 120 may be made in addition to one other visit the beneficiary had during the same day.

All DSMT programs must be accredited as meeting quality standards by a CMS approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association, American Association of Diabetes Educators and the Indian Health Service as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered. Certified providers may be asked to submit updated accreditation documents at any time or to submit outcome data to an organization designated by CMS.

Enrollment of DMEPOS Suppliers

The DMEPOS suppliers are reimbursed for diabetes training through local carriers. In order to file claims for DSMT, a DMEPOS supplier must be enrolled in the Medicare program with the National Supplier Clearinghouse (NSC). The supplier must also meet the quality standards of a CMS-approved national accreditation organization as stated above. DMEPOS suppliers must obtain a provider number from the local carrier in order to bill for DSMT.

The carrier requires a completed Form CMS-855, along with an accreditation certificate as part of the provider application process. After it has been determined that the quality standards are met, a billing number is assigned to the supplier. Once a supplier has

received a National Provider Identification (NPI) number, the supplier can begin receiving reimbursement for this service.

Carriers should contact the National Supplier Clearinghouse (NSC) according to the instruction in Pub 100-08, the Medicare Program Integrity Manual, Chapter 10, "Healthcare Provider/Supplier Enrollment," to verify an applicant is currently enrolled and eligible to receive direct payment from the Medicare program.

The applicant is assigned specialty 87.

Any DMEPOS supplier that has its billing privileges deactivated or revoked by the NSC will also have the billing number deactivated by the carrier.

300.3 - Frequency of Training

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A - Initial Training

The initial year for DSMT is the 12 month period following the initial date.

Medicare will cover initial training that meets the following conditions:

- Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS codes G0108 or G0109;
- Is furnished within a continuous 12-month period;
- Does not exceed a total of 10 hours* (the 10 hours of training can be done in any combination of 1/2 hour increments);
- With the exception of 1 hour of individual training, training is usually furnished in a group setting, which can contain other patients besides Medicare beneficiaries, and;
- One hour of individual training may be used for any part of the training including insulin training.

* When a claim contains a DSMT HCPCS code and the associated units cause the total time for the DSMT initial year to exceed '10' hours, a CWF error will set.

B - Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than 2 hours individual or group training per beneficiary per year;

- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;

- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;

- Follow-up training is furnished in increments of no less than one-half hour*; and

- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

  *When a claim contains a DSMT HCPCS code and the associated units cause the total time for any follow-up year to exceed 2 hours, a CWF error will set.

300.4 - Coverage Requirements for Individual Training
(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:

- No group session is available within 2 months of the date the training is ordered;

- The beneficiary's physician (or qualified non-physician practitioner) documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing or language limitations or other such special conditions as identified by the treating physician or non-physician practitioner, that will hinder effective participation in a group training session; or

- The physician orders additional insulin training.

- The need for individual training must be identified by the physician or non-physician practitioner in the referral.

  NOTE: If individual training has been provided to a Medicare beneficiary and subsequently the carrier or intermediary determines that training should have been provided in a group, carriers and intermediaries down-code the reimbursement from individual to the group level and provider education would be the appropriate actions instead of denying the service as billed.

300.4.1 – Incident-To Provision
(Rev. 13, 05-13-04)

The "incident to" requirements of section 1861(s)(2)(A) of the Social Security Act do not apply to DSMT services. Section 1861 (s)(2)(S) of the Act authorizes DSMT in a stand

alone provision. DSMT services are covered only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed and refers the patient to the DSMT program. The referral must be done under a comprehensive plan of care related to the beneficiary's diabetic condition. Training may be furnished by a physician, individual, or entity that meets the following conditions:

- Furnishes other services for which direct Medicare payment may be made;

- May properly receive Medicare payment under 42CFR 424.73 or 424.80 which set forth prohibitions on assignment and reassignment of claims;

- Submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS under 42CFR 410.142 to meet one of the sets of quality standards described in 42 CFR 410.144; and

Provides documentation to CMS, as requested, including diabetes outcome measurements set forth at CFR 410.146.

Any certified providers or suppliers that provide other individual items or services under Medicare that meet CMS's quality standards and meet the conditions for CMS approval pursuant to 42 CFR 410.145, may receive reimbursement for diabetes training. Entities are more likely than individuals to bill for DSMT services. These certified providers must be currently receiving payment for other Medicare services.

300.5 - Payment for DSMT

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Payment for DSMT may only be made to any provider that bills Medicare for other individual Medicare services and may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.

See Pub. 100-04, chapter 18, section 120 for specific payment information for physicians and all provider types.

300.5.1 - Special Claims Processing Instructions for FIs

(Rev. 24, Issued: 10-29-04, Effective: 01-01-05, Implementation: 01-03-05)

- Coding and Payment Requirements

The provider bills for DSMT on Form CMS-1450 or its electronic equivalent. The cost of the service is billed under revenue code 942 in FL 42 "Revenue Code." The provider will report HCPCS codes G0108 or G0109 in FL 44 "HCPCS/Rates." The definition of the HCPCS code used should be entered in FL 43 "Description."

- Applicable Bill Types

  The appropriate bill types are 12x, 22x, 13x, 34x (can be billed if service is outside of the treatment plan), 72x, 74x, 75x, 83x and 85x.

310 – Kidney Disease Patient Education Services

(Rev. 117; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Patients can be classified into 5 stages based on their glomerular filtration rate (GFR, how quickly blood is filtered through the kidneys), with stage I having kidney damage with normal or increased GFR to stage V with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

Beneficiaries with CKD may benefit from kidney disease education (KDE) interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

Effective for claims with dates of service on and after January 1, 2010, Section 152(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) covers KDE services under Medicare Part B. KDE services are designed to provide beneficiaries with Stage IV CKD comprehensive information regarding: the management of comorbidities, including delaying the need for dialysis; prevention of uremic complications; all therapeutic options (each option for renal replacement therapy, dialysis access options, and transplantation); ensuring that the beneficiary has opportunities to actively participate in his/her choice of therapy; and that the services be tailored to meet the beneficiary's needs.

APPENDIX R
ADVANCE CARE PLANNING

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9271

Related Change Request (CR) #: CR 9271

Related CR Release Date: December 22, 2015

Effective Date: January 1, 2016

Related CR Transmittal #: R216BP and R3428CP

Implementation Date: January 4, 2016

Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services provided as an optional element of the Annual Wellness Visit (AWV) to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9271 informs providers to waive the deductible and the coinsurance for ACP **when furnished as an optional element of an AWV**. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) made the Current Procedural Terminology (CPT) codes for ACP separately payable for Medicare. The change in policy will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

In addition, CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, would be an optional element of the AWV. Effective January 1, 2016, when ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and G0439. CPT codes 99497 and 99498 used to describe ACP are separately payable under the Medicare Physician Fee Schedule (MPFS). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible would not be applied for ACP. Under that circumstance, both the ACP and AWV must also be billed together on the same claim. In order to have the deductible and coinsurance waived for ACP when performed with an AWV, the ACP code(s) must be billed with modifier 33 (Preventive services). Since payment for an AWV is limited to only once a year, the deductible and coinsurance for ACP billed with an AWV can only be waived once a year.

Critical Access Hospitals (CAHs) may also bill for these professional services provided on or after January 1, 2016, using type of bill 85X with revenue codes 96X, 97X, and 98X. The CAH Method II payment will be based on the lesser of the actual charge or the facility-specific MPFS.

However, the deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Additional Information

The official instruction, CR9271, was issued to your MAC regarding this change via two transmittals. The first updates the "Medicare Benefit Policy Manual" and it is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R216BP.pdf** on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and it is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3428CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

APPENDIX S
OUTPATIENT PT/OT/SLP SERVICES

CMS Manual System

Pub. 100-02 Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 5 **Date: JANUARY 9, 2004**

CHANGE REQUEST 2859 & 2779

I. SUMMARY OF CHANGES: This transmittal clarifies the time period when a physician must evaluate the patient, corrects omission of non-physician practitioners and occupational therapy services and includes Medicare enrollment policy requirements for physical therapists and occupational therapists in private practice.

NEW/REVISED MATERIAL - EFFECTIVE DATE: February 11, 2004
***IMPLEMENTATION DATE: March 15, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/220/Coverage of Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Service under Medical Insurance
R	15/220.3/Conditions for Coverage of Outpatient Physical Therapy, Occupational Therapy or Speech-Language Pathology Services
R	15/220.3.1/Physician's Certification and Recertification
R	15/220.3.2/Outpatient Must be Under Care of Physician
R	15/220.3.3/Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Services Furnished Under Plan
R	15/230/Payable Rehabilitation Services
R	15/230.1/Services Furnished by a Physical or Occupational Therapist in Private Practice

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

220 - Coverage of Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services under Medical Insurance

(Rev. 5, 01-09-04)

B3-2200, A3-3147, HO-241.1

Coverage of outpatient physical therapy, occupational therapy, and outpatient speech-language pathology services under Part B includes such services furnished directly by the provider and also services furnished under arrangements made by a provider, a physician, a *non-physician practitioner,* a therapist or a supplier qualified to provide the service.

This includes individual practitioners and approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, SNFs, HHAs, CORFs, and other rehabilitation facilities. To qualify as providers of services, clinics, rehabilitation agencies, and public health agencies must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made.

Reimbursement for therapy provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Reimbursement for therapy provided by home health agencies under a plan of treatment is included in the home health PPS rate. Some therapy services are included in hospital outpatient PPS and some are paid under the therapy fee schedule (see the Medicare Claims Processing instructions for a description of applicable rules).

Therapy may be billed by a home health agency on bill type 34x if there are no home health services billed under a home health plan of care at the same time, and there is a valid therapy plan of treatment (e.g., the patient is not homebound).

220.3 - Conditions for Coverage of Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

(Rev. 5, 01-09-04)

B3-2206, A3-3148, HO-242

Refer to §230.4 for independent practitioner rules.
Outpatient physical therapy, occupational therapy, or speech-language pathology services furnished to a beneficiary by a participating provider are payable only when furnished in accordance with the following conditions:

- Physician's *or non-physician practitioner's* certification and recertification;
- Outpatient must be under the care of a physician *or non-physician practitioner*;
- Outpatient physical therapy, *occupational therapy* or speech-language pathology services furnished under a plan; and
- Services must be furnished on an outpatient basis.

Each of these conditions is discussed separately in the subsections that follow.

In addition, outpatient physical therapy, *occupational and speech-language pathology* services must meet all of the conditions set forth in the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §100 and §220, and its subsections of this chapter.

220.3.1 - Physician's Certification and Recertification

(Rev. 5, 01-09-04)

B3-2206.1, A3-3148.1, HO-242.1, A3-3350, A3-3322

A - Content of Physician's Certification

The contractor must not pay for outpatient physical therapy*, occupational therapy* or speech-language pathology services unless a physician *or non-physician practitioner* certifies that:

- The services are or were required by the patient.

- A plan for furnishing such services is or was established and periodically reviewed by the physician*, or non-physician practitioner*. Either the physician*, or non-physician practitioner* or the qualified physical therapist providing such services establishes a plan of treatment for outpatient physical therapy services. *Either the physician, or non-physician practitioner or the qualified occupational therapist providing such services establishes a plan of treatment for outpatient occupational therapy services.* Either the physician*, or non-physician practitioner* or the speech-language pathologist providing such services establishes a plan of treatment for outpatient speech-language pathology services.

However, a physician *or non-physician practitioner* must periodically review a plan established by a speech-language pathologist*, occupational therapist* or physical therapist. (See §220.3.3.) See §230 for specific requirements for a plan established for physical*, occupational, and speech-language pathology* therapy services.

- The outpatient physical therapy*, occupational therapy* or speech-language pathology services are or were furnished while the patient was under the care of a physician *or non-physician practitioner*. (See §220.3.2.)

Since the certification is closely associated with the plan of treatment, the same physician *or non-physician practitioner* who established or reviews the plan of treatment must certify the necessity for services. The plan must be written and developed by the physician *or non-physician practitioner* caring for the patient. The carrier will obtain certification at the time the plan of treatment is established or as soon thereafter as possible.

Physician means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine legally authorized to practice by the State in which they perform the services *and optometrist (for low vision only)*. In addition, physician certifications and recertifications by doctors of podiatric medicine *or optometry* must be consistent with the scope of the professional services provided by a doctor of podiatric medicine *or optometry* as authorized by applicable State law.

B - Recertification

When outpatient physical therapy*, occupational therapy* or speech-language pathology services are continued under the same plan of treatment for a period of time, the physician *or non-physician practitioner* must recertify at intervals of at least once every 30 days *from the date last seen by the referring physician or non-physician practitioner* that there is a continuing need for such services and estimate how long services are needed. *Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan.* The form of the recertification and the manner of obtaining timely recertification is up to the individual facility and/or practitioner.

C - Method and Disposition of Certifications

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the carrier can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician *or non-physician practitioner* is retained by the individual facility and/or practitioner, which also certifies on the billing form that the requisite certifications and recertifications have been made by the physician *or non-physician practitioner* and are on file when it forwards the request for payment to the carrier.

D - Delayed Certification

The individual facility and/or practitioner must obtain certifications and recertifications as promptly as possible. Payment is not made unless the necessary certifications are

secured. In addition to complying with the usual content requirements, delayed certifications and recertifications are to include an explanation for the delay and any other evidence the clinic considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained is left to the individual facility and/or practitioner.

220.3.2 - Outpatient Must be Under Care of Physician

(Rev. 5, 01-09-04)

B3-2206.2, A3-3148.2, HO-242.2

Outpatient physical therapy, occupational therapy, or speech-language pathology services must be furnished to an individual who is under the care of a physician *or non-physician practitioner who certifies the patient's outpatient therapy services. If the therapy service continues past the 60th day, there must be evidence in the patient's clinical record, which is a part of the therapy documentation, that a physician or non-physician practitioner has seen him/her within 60 days after the therapy began and every 30 days past the 60th day. If the requirement is not met, the therapy services are not covered (reasonable and necessary). The 60-day period begins with the therapist or pathologist initial encounter with the patient, i.e., the day when the evaluation is performed. In the event that an evaluation is not indicated the first treatment session begins the 60-day period. The therapist's or pathologist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral. For continuity of care the physician or non-physician practitioner who certifies the patient's need for outpatient therapy services is the same person who meets the visit requirements. In addition, timing of recertifications and the visit requirements should coincide*. However, the physician *or non-physician practitioner* still makes the necessary certifications. (See §§220.3.1, 220.3.3, and 220.3.4.)

220.3.3 - Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services Furnished Under Plan

(Rev. 5, 01-09-04)

B3-2206.3, A3-3148.3, HO-242.3

Outpatient physical therapy, occupational therapy, or speech-language pathology services are furnished under a plan established by:

- A physician *or non-physician practitioner* after any necessary consultation with the physical therapist, occupational therapist, or speech-language pathologist, as appropriate;
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or

- The speech-language pathologist that will provide the speech-language pathology services.

The plan must be established (that is, reduced to writing either by the person who established the plan or by the provider or clinic itself when it makes a written record of that person's oral orders) before treatment is begun. The plan is promptly signed by the ordering physician, *non-physician practitioner,* therapist, or pathologist and incorporated into the facility's permanent record for the patient.

The plan relates the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology *to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients. However, if the provider chooses to furnish a particular service, it is bound by its agreement not to charge any individual or other person for items or services for which the individual is entitled to have payment made under the program. Thus, whenever a hospital or SNF furnishes outpatient physical therapy, occupational therapy, or speech-language pathology services to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance.*

230 - Payable Rehabilitation Services

(Rev. 5, 01-09-04)

B3-2210

A - General

To be covered PT*, OT or speech-language pathology* services, the services must relate directly and specifically to an active written treatment regimen established by the physician *or non-physician practitioner* after any needed consultation with the qualified *PT, OT, or speech-language pathologist* and must be reasonable and necessary to the treatment of the individual's illness or injury. The physician, *non-physician practitioner* or the qualified therapist providing such services may establish a plan of treatment for outpatient PT, *OT, or speech-language pathology* services.

There is a limit for the amount of therapy expenses that is recognized as payable for some years. See the Medicare Claims Processing Manual, Chapter 5, §10.2, for a complete description of this financial limitation.

B - Reasonable and Necessary

To be considered reasonable and necessary the following conditions must be met:

The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition;

The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified *PT, OT, or speech language pathologist* or under the therapist's supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary PT, *OT or speech-language pathology* services, even if they are performed or supervised by a therapist. (When the carrier determines the services furnished were of a type that could have been *safely and related to the maintenance of function (see subsection D) do not require the skills of a qualified physical therapist.*

230.1 - Services Furnished by a Physical or Occupational Therapist in Private Practice

(Rev. 5, 01-09-04)

B3-2215

Private practice includes a therapist whose practice is an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician group or groups that are not professional corporations, if allowed by State law. Section 1861(r) of the Act

defines a physician as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicines, a doctor of optometry and a chiropractor who is legally authorized to practice medicines by the State in which he performs such function or action and who is acting within the scope of his license when he performs such functions. Physician group practices may employ PTPPs and/or OTPPs if this employee relationship is permitted by State law. However, therapy provided to Medicare beneficiaries must be done while under the "care of a physician who is a doctor of medicine, osteopathy, podiatric medicine or optometry (low vision rehabilitation only)" or a non-physician practitioner. These physicians or non-physician practitioners provide referrals, certification and recertifications of plans of care for Medicare beneficiaries. As defined in the statute, chiropractors and doctors of dental surgery or dental medicine are not considered physicians for these services and are not able to refer patients for rehabilitation services nor establish therapy plans of care.

For purposes of this provision a physician group practice is defined as one or more physicians and/or non-physician practitioners that desire to bill Medicare as one entity. For further details contact the Office of Financial Management, Division of Provider and Supplier Enrollment.

Private practice also includes a therapist who is practicing therapy as an employee of one of the above or of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of a provider. A provider as defined in §400.202 includes a hospital, CAH, SNF, HHA, hospice, CORF, CMHC, or an organization qualified under part 485, subpart H (conditions of participation of clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy, occupational therapy and speech-language pathology services) as a clinic, rehabilitation agency, or public health agency.

Services should be furnished in the therapist's or group's office or in the patient's home. The office is defined as the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space would have to be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For example, a therapist in private practice may furnish aquatic therapy in a community center pool. The practice would have to rent or lease the pool for those hours, and the use of the pool during that time would have to be restricted to the therapist's patients, in order to recognize the pool as part of the therapist's own practice office during those hours.

Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary. For PTPPs and OTPPs, assignment is mandatory. When the PT or OT is the "supplier" of services, the rules for private therapy practice must be followed. When the physician or non-physician practitioner is the "supplier" of services, then the "incident to" rules must be followed.

The PTPPs or OTPPs in a physician group can be either salaried W-2 employees or contract 1099 employees. The PTPP/OTPP contract 1099 employee must follow current reassignment rules that indicate that these services must be provided on the premises that are rented, owned or leased by the physician group, just as required for physicians in a group practice who are reassigning their benefits to the physician group practice

Therapists in private practice employed by physician groups or non-professional corporations who enroll in Medicare as PTPP or OTPP need not be supervised. The therapist must personally supervise therapy assistants. Personal supervision requires that the therapist be in the room during the performance of the service. (For coverage guidelines, see §230 for physical therapy, and §230.4 for occupational therapy.) Medicare payment is based on the Medicare physician fee schedule less coinsurance and any deductible amounts due.

There is a limit for the amount of therapy expenses that is recognized as payable for some years. See the Medicare Claims Processing Manual, Chapter 5, §10.2, for a complete description of this financial limitation.

NOTE: The limit on expenses applies only to items and services covered under the therapy benefit. It does not apply to items covered under a separate benefit; e.g., braces that are furnished and billed *by an occupational or physical therapist and billed as durable medical equipment.*

NOTE: Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision.

APPENDIX T1
MEDICARE ADMINISTRATIVE CONTRACTORS CONTACT LIST

Medicare Fee-for-Service Provider Enrollment Contact List

Medicare operations are managed by independent contractors known as fee-for-service contractors.

The Medicare fee-for-service contractor serving your State or jurisdiction will answer your enrollment questions and process your enrollment application.

An A/B MAC processes enrollment applications submitted by Part B suppliers (physicians, non-physician practitioners, and the following organizations):

Ambulance Service Supplier	Independent Diagnostic Testing Facility
Ambulatory Surgical Center	Mammography Center
Clinics & Group Practices	Portable X-ray Supplier
Independent Clinical Laboratory	Radiation Therapy Center

Note: If your supplier type is not shown above, contact the designated carrier before you submit an enrollment application.

An A/B MAC processes enrollment applications submitted by the following Part A Providers/Organizations:

Community Mental Health Center	Histocompatibility Laboratory	Organ Procurement Organization
Comprehensive Outpatient Rehab Facility	Home Health Agency (HHA)	Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services
Critical Access Hospital	Hospice	Religious Non-Medical Health Care Institution
End-Stage Renal Disease Facility	Hospital	Rural Health Center
Federally Qualified Health Center	Indian Health Services Facility	Skilled Nursing Facility

Note: If your provider or supplier type is not shown above, contact the designated A/B MAC before you submit an enrollment application

The **National Supplier Clearinghouse** processes enrollment applications submitted by Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers.

ALABAMA

Part A Contractor	Cahaba GBA, LLC	877-567-7271	Provider Enrollment – Part A, P.O. Box 6168, Indianapolis, IN 46206-6168	http://www.cahabagba.com
Part B Contractor	Cahaba GBA, LLC	877-567-7271	Provider Enrollment – Part B, P.O. Box 6169 Indianapolis, IN 46206-6168	http://www.cahabagba.com
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

ALASKA

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6720 Fargo, ND 58108-6720	http://www.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6703, Fargo, ND 58108-6703	http://www.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

AMERICAN SAMOA

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6773, Fargo, ND 58108-6773	www.noridianmedicare.com
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6777, Fargo, ND 58108-6777	www.noridianmedicare.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

ARIZONA

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6730, Fargo, ND 58108-6730	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6704, Fargo, ND 58108-6704	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

ARKANSAS

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

CALIFORNIA

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6770, Fargo, ND 58108-6770	https://med.noridianmedicare.com
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Northern California Provider Enrollment, P.O. Box 6774, Fargo, ND 58108-6774 Southern California Provider Enrollment, P.O. Box 6775, Fargo, ND 58108-6775	https://med.noridianmedicare.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

COLORADO

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	1 Cameron Hill Cir, Ste 0063, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

CONNECTICUT

Part A Contractor	National Government Services, Inc.	855-593-8047	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142 Columbia, SC 29202-3142	http://www.palmettogba.com/nsc

DISTRICT OF COLUMBIA

Part A Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

DELAWARE

Part A Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

FLORIDA

Part A Contractor	First Coast Service Options	877-602-8816	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Part B Contractor	First Coast Service Options	866-454-9007	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

GEORGIA

Part A Contractor	Cahaba GBA, LLC	877-567-7271	Provider Enrollment - Part A, P.O. Box 6168, Indianapolis, IN 46206-6168	http://www.cahabagba.com
Part B Contractor	Cahaba GBA, LLC	877-567-7271	Provider Enrollment, P.O. Box 6169, Indianapolis, IN 46206-6168	http://www.cahabagba.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

GUAM

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6773, Fargo, ND 58108-6773	https://med.noridianmedicare.com
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6777, Fargo, ND 58108-6777	https://med.noridianmedicare.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

HAWAII

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6773, Fargo, ND 58108-6773	https://med.noridianmedicare.com
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6777, Fargo, ND 58108-6777	https://med.noridianmedicare.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

IDAHO

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6726, Fargo, ND 58108-6726	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6701, Fargo, ND 58108-6701	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

ILLINOIS

Part A Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	877-908-8476	Provider Enrollment, P.O. Box 6475, Indianapolis, IN 46206-6475	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P. O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

INDIANA

Part A Contractor	Wisconsin Physicians Service	866-234-7331	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-234-7331	Medicare Part B Provider Enrollment, P.O. Box 8248, Madison, Wisconsin 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

IOWA

Part A Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment, P.O.Box 8248, Madison, WI 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500 (HHA) 866-539-5592 (Hospice)	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

KANSAS

Part A Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment, P.O.Box 8248, Madison, WI 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500 (HHA) 866-539-5592 (Hospice)	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

KENTUCKY

Part A Contractor	CGS Administrators LLC	866-590-6703	P.O. Box 20004, Nashville, TN 37202	http://www.cgsmedicare.com/
Part B Contractor	CGS Administrators LLC	866-276-9558	J-15 Part B Provider Enrollment CGS Administrators, LLC P.O. Box 20017 Nashville, TN 37202	http://www.cgsmedicare.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

LOUISIANA

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MAINE

Part A Contractor	National Government Services, Inc.	855-593-8047	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MARYLAND

Part A Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MASSACHUSETTS

Part A Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MICHIGAN

Part A Contractor	Wisconsin Physicians Service	866-234-7331	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-234-7331	Provider Enrollment, P.O. Box 8248, Madison, Wisconsin 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46205-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MINNESOTA

Part A Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	877-908-8476	Provider Enrollment, P.O. Box 6475, Indianapolis, IN 46206-6475	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MISSISSIPPI

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MISSOURI

Part A Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment, P.O.Box 8248, Madison, WI 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500 (HHA) 866-539-5592 (Hospice)	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

MONTANA

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, P.O. Box 6732, Fargo, ND 58108-6732	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, P.O. Box 6735, Fargo, ND 58108-6735	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEBRASKA

Part A Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment Part A P.O. Box 8248 Madison, WI 53708-8248	www.wpsgha.com
Part B Contractor	Wisconsin Physicians Service	866-518-3285	Provider Enrollment, P.O.Box 8248, Madison, WI 53708-8248	www.wpsgha.com
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEVADA

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6772, Fargo ND, 58108-6772	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6776, Fargo ND, 58108-6776	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEW HAMPSHIRE

Part A Contractor	National Government Services, Inc.	855-593-8047	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEW JERSEY

Part A Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEW MEXICO

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NEW YORK

Part A Contractor	National Government Services, Inc.	888-379-3807	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	855-593-8047	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NORTH CAROLINA

Part A Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment, 2300 Springdale Drive, Building One, Camden, SC 29020	http://www.palmettogba.com/
Part B Contractor	Palmetto GBA	855-696-0705	Part B Provider Enrollment (AG-310) P.O. Box 100190 Columbia, SC 29202-3190	http://www.palmettogba.com
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NORTH DAKOTA

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6709, Fargo, ND 58108-6709	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6706, Fargo, ND 58108-6706	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

NORTHERN MARIANA ISLANDS

Part A Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6773, Fargo, ND 58108-6773	https://med.noridianmedicare.com
Part B Contractor	Noridian Healthcare Solutions	855-609-9960	Provider Enrollment, PO Box 6777, Fargo, ND 58108-6777	https://med.noridianmedicare.com
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

OHIO

Part A Contractor	CGS Administrators LLC	866-590-6703	P.O. Box 20004, Nashville, TN 37202	http://www.cgsmedicare.com/
Part B Contractor	CGS Administrators LLC	866-276-9558	J-15 Part B Provider Enrollment CGS Administrators, LLC P.O. Box 20017 Nashville, TN 37202	Http://www.cgsmedicare.com
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

OKLAHOMA

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

OREGON

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, P.O. Box 6726, Fargo, ND 58108-6726	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6702, Fargo, ND 58108-6702	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

PENNSYLVANIA

Part A Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services, P.O. Box 3157 Mechanicsburg, PA 17055-1836	www.novitas-solutions.com
Home Health and Hospice Contractor	CGS Administrators LLC	866-276-9558	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

PUERTO RICO

Part A Contractor	First Coast Service Options	877-908-8433	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Part B Contractor	First Coast Service Options	877-715-1921	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

RHODE ISLAND

Part A Contractor	National Government Services, Inc.	855-593-8047	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

SOUTH CAROLINA

Part A Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
Part B Contractor	Palmetto GBA	855-696-0705	Part B Provider Enrollment (AG-310), P.O. Box 100190, Columbia, SC 29202-3190	http://www.palmettogba.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

SOUTH DAKOTA

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6733, Fargo, ND 58108-6733	http://www.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6707, Fargo, ND 58108-6707	http://www.noridianmedicare.com/
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-9652	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

TENNESSEE

Part A Contractor	Cahaba GBA	877-567-7271	Provider Enrollment - Part A, P.O. Box 6168, Indianapolis, IN 46206-6168	http://www.cahabagba.com
Part B Contractor	Cahaba GBA	877-567-7271	Provider Enrollment, P.O. Box 6169, Indianapolis, IN 46206-6168	http://www.cignamedicare.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

TEXAS

Part A Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Part B Contractor	Novitas Solutions	855-252-8782, Option 4	JH Provider Enrollment Services, P.O. Box 3095, Mechanicsburg, PA 17055-1813	http://www.novitas-solutions.com/
Home Health and Hospice Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331), P.O. Box 100144, Columbia, SC 29202-3144	http://www.palmettogba.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

U.S. VIRGIN ISLANDS

Part A Contractor	First Coast Service Options	877-908-8433	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Part B Contractor	First Coast Service Options	877-715-1921	Provider Enrollment, P.O. Box 44021, Jacksonville, FL 32231-4021	http://www.fcso.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

UTAH

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6724, Fargo, ND 58108-6724	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	P.O. Box 6725, Fargo, ND 58108-6725	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	CGS Administrators LLC	866-276-9558	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

VERMONT

Part A Contractor	National Government Services, Inc.	855-593-8047	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	888-379-3807	Part B Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Part A Provider Enrollment, P.O. Box 7149, Indianapolis, IN 46207-7149	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

VIRGINIA

Part A Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331) P.O. Box 100144 Columbia, SC 29202-3144	http://www.palmettogba.com
Part B Contractor	Palmetto GBA	855-696-0705	Part B Provider Enrollment (AG-310) P.O. Box 100190 Columbia, SC 29202-3190	http://www.palmettogba.com
Home Health and Hospice Contractor	CGS Administrators LLC	855-696-0705	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

VIRGINIA (counties of Arlington and Fairfax and City of Alexandria)

Part B Contractor	Novitas Solutions, Inc.	877-235-8073, Option 4	Provider Enrollment Services PO Box 3157 Mechanicsburg, PA 17055-1836	http://www.novitas-solutions.com/

WASHINGTON

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, P.O. Box 6720, Fargo, ND 58108-6720	https://med.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, P.O. Box 6700, Fargo, ND 58108-6700	https://med.noridianmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

WEST VIRGINIA

Part A Contractor	Palmetto GBA	855-696-0705	Part A Provider Enrollment (AG-331) P.O.Box 100144 Columbia, SC 29202-3144	http://www.palmettogba.com
Part B Contractor	Palmetto GBA	855-696-0705	Part B Provider Enrollment (AG-310) P.O.Box 100190 Columbia, SC 29202-3190	http://www.palmettogba.com/
Home Health and Hospice Contractor	CGS Administrators LLC	877-299-4500	P.O. Box 20016, Nashville, TN 37202	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

WISCONSIN

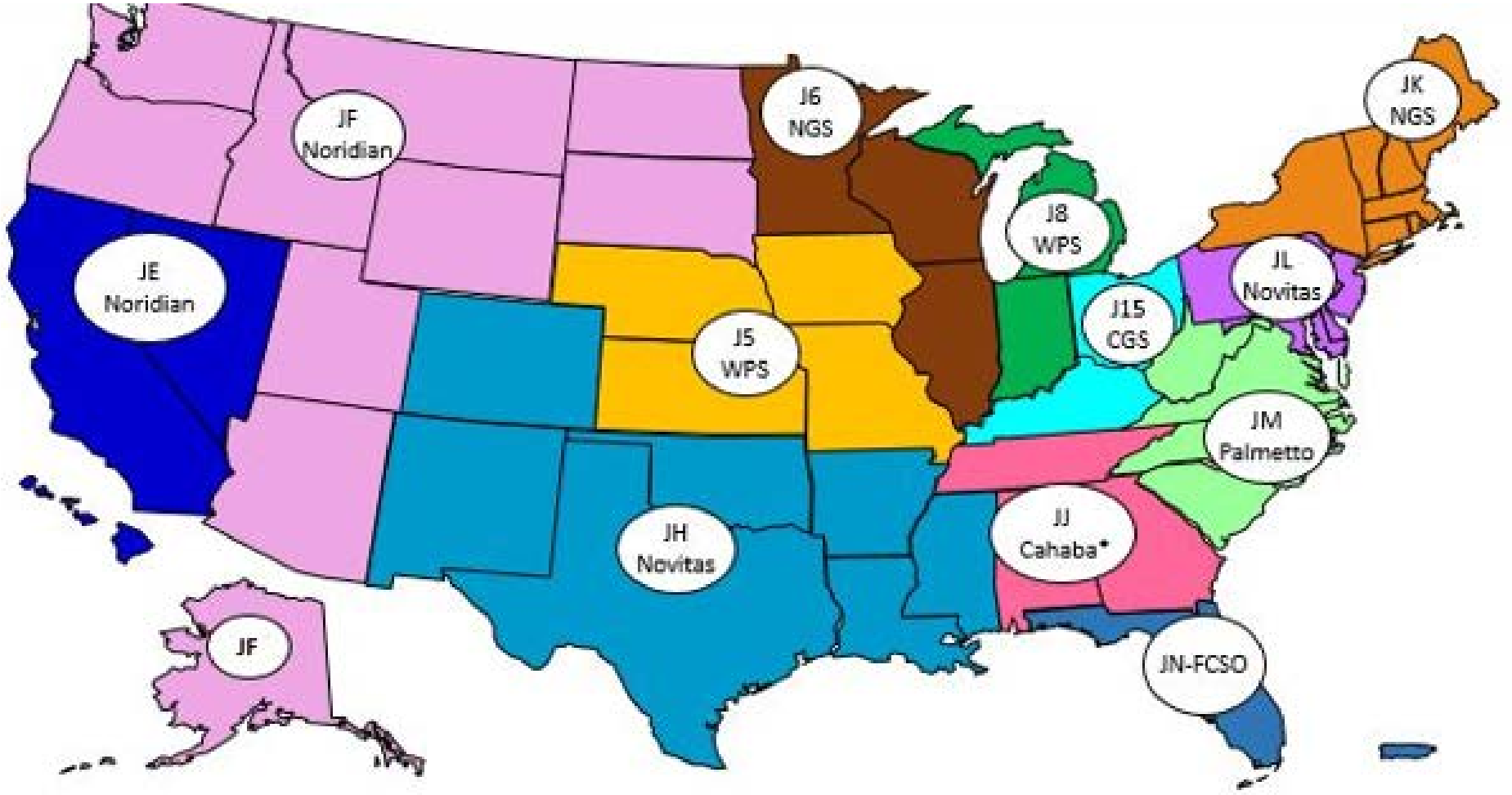
Part A Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
Part B Contractor	National Government Services, Inc.	877-908-8476	Provider Enrollment, P.O. Box 6475, Indianapolis, IN 46206-6475	http://www.ngsmedicare.com/
Home Health and Hospice Contractor	National Government Services, Inc.	855-834-5596	Provider Enrollment, P.O. Box 6474, Indianapolis, IN 46206-6474	http://www.ngsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

WYOMING

Part A Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, Medicare Part A, P.O. Box 6734, Fargo, ND 58108-6734	http://www.noridianmedicare.com/
Part B Contractor	Noridian Healthcare Solutions	877-908-8431	Provider Enrollment, Medicare Part B, P.O. Box 6708, Fargo, ND 58108-6708	http://www.noridianmedicare.com/
Home Health and Hospice Contractor	CGS Administrators LLC	866-276-9558	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.cgsmedicare.com/
National Supplier Clearinghouse	Palmetto GBA	866-238-9652	P.O. Box 100142, Columbia, South Carolina 29202-3142	http://www.palmettogba.com/nsc

APPENDIX T2
MAC JURISDICTION MAP

A/B MAC Jurisdictions
as of October 2017



*NOTE: In September 2017, CMS awarded the Jurisdiction J contract to Palmetto GBA, LLC. The implementation is under way and CMS anticipates the transition will be complete in the early part of 2018.

APPENDIX U
MEDICARE APPEALS PROCESS

mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

MEDICARE PARTS A & B APPEALS PROCESS

Level 1 - Redetermination by a Medicare Administrative Contractor (MAC)

Level 2 - Reconsideration by a Qualified Independent Contractor (QIC)

Level 3 - Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)

Level 4 - Review by the Medicare Appeals Council (Council)

Level 5 - Judicial review in U.S. District Court

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

TABLE OF CONTENTS

LIST OF TABLES

OVERVIEW

This booklet provides health care professionals with information about each level of appeal in Original Medicare (Parts A and B) as well as additional resources for information on related topics. It describes how the Medicare appeals process applies to providers, physicians, and suppliers. In this booklet, the pronouns "I" or "you" refer to parties and appellants participating in an appeal.

Find more information about appeals on the Original Medicare (Fee-For-Service) Appeals webpage and beneficiary-specific appeals information on the Medicare.gov Original Medicare Appeals webpage. This booklet does not cover Medicare Part C or Part D Appeals. However, you may find Part C Appeals and Part D Appeals resources in the Resources section of this booklet (Table 7).

APPEALING MEDICARE DECISIONS

Original Medicare has five levels in the claims appeal process:

Level 1 - Redetermination by a Medicare Administrative Contractor (MAC)

Level 2 - Reconsideration by a Qualified Independent Contractor (QIC)

Level 3 - Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)

Level 4 - Review by the Medicare Appeals Council (Council)

Level 5 - Judicial review in U.S. District Court

Make all appeal requests in writing.

HELPFUL TERMS

Amount in Controversy (AIC): The threshold dollar amount remaining in dispute that is required for a Level 3 and Level 5 appeal. The AIC increases annually by a percentage increase tied to a consumer price index.

Appeal: The process used when a party (for example, a beneficiary, provider, or supplier) disagrees with an initial determination or a revised determination for health care items or services.

Appellant: A person or entity filing an appeal.

Attorney Adjudicator: A licensed attorney employed by the U.S. Department of Health & Human Services (HHS) OMHA with knowledge of Medicare coverage, payment laws and guidance, who is authorized to issue decisions on reviews of QIC dismissals, and decisions when an ALJ is not conducting a hearing.

Determination: A decision made to pay in full, pay in part, or deny a claim.

Escalation: When an appellant requests that an appeal pending at the QIC level or higher be moved to the next level because the adjudicator was not able to make a decision within a specified time.

Medicare Redetermination Notice (MRN): A letter informing a party about the MAC's decision on a redetermination.

Nonparticipating: Physicians and suppliers who choose to either accept or not accept Medicare assignment on a claim-by-claim basis. Nonparticipating physicians and suppliers have limited appeal rights.

On-the-Record: A decision based solely on the information within the administrative record along with any evidence submitted with the request for OMHA review. A hearing will not be held.

Party: A person or entity with standing to appeal an initial determination or subsequent administrative appeal determination or decision.

APPOINTING A REPRESENTATIVE

At any time, a party may appoint any individual, including an attorney, to represent him or her during the claim or appeal process. The representative provides assistance and expertise.

To appoint a representative, the party and representative must complete the Appointment of Representative (Form CMS-1696) or another written document that must:

- Be signed and dated by the party and the representative (the representative's signature must be dated within 30 days of the party's signature)
- Include a statement appointing the representative to act for the party
- Include a written explanation of the purpose and scope of the representation
- Include the names, phone numbers, and addresses of both the party and the representative
- Include the representative's professional status or relationship to the party
- Contain a unique identifier of the represented party
    - If the party is the beneficiary, the Medicare number must be included. If the party is a provider or supplier, the National Provider Identifier (NPI) must be included.

The appointment is valid for 1 year from the date it contains the signatures of both the party and appointed representative, and can be used for multiple claims or appeals during this year, unless the party specifically withdraws the representative's authority. An appointment instrument submitted with an appeal request is valid beyond 1 year for subsequent levels of appeal for the items, services, or claims at issue.

REQUIREMENTS FOR APPOINTMENT OF REPRESENTATIVES

Find the requirements for appointing a representative in the Medicare Claims Processing Manual, Chapter 29, Section 270.

Transfer of Appeal Rights to Nonparticipating Physicians and Suppliers

Beneficiaries may transfer their appeal rights to nonparticipating physicians or suppliers who provide the items or services and do not otherwise have appeal rights. To transfer the appeal rights, the beneficiary and nonparticipating physician or supplier must complete and sign the Transfer of Appeal Rights (Form CMS-20031).

FIRST LEVEL OF APPEAL: REDETERMINATION BY A MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)

A redetermination is the first level of appeal after the initial determination on a claim. It is a look at the claim by MAC staff not involved in the initial determination.

Table 1. Redetermination Frequently Asked Questions (FAQs) and Answers

Question	Answer
When must I file a request?	You must file a request for redetermination within **120 days** from the date of receipt of the Remittance Advice (RA) that lists the initial determination.
How do I file a request?	File your request **in writing** by following instructions provided in the RA. You may use the Medicare Redetermination Request (Form CMS-20027), or any written document, so long as it contains the required elements listed in the RA. Your request must be sent to the address listed on the RA or filed in person (or follow instructions from your MAC on filing electronically). Find more information about the requirements for requesting a redetermination on the First Level of Appeal: Redetermination by a Medicare Contractor webpage. **REMEMBER** • You or your representative must include your **name and signature** • Attach any supporting documentation to your redetermination request • Keep a copy of everything you send to Medicare as part of your appeal
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	**MAC staff** unassociated with the initial claim determination perform the redetermination.
How long does it take to make a decision?	MACs generally issue a decision within **60 days** of receipt of the request for redetermination. You will receive notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC, or if the initial decision is reversed and the claim is paid in full, you will receive a revised RA.

NOTE: MLN Matters® Article Correction of Minor Errors and Omissions Without Appeals provides information about Medicare rules that enable you to correct minor errors and omissions on claims without initiating the appeals process.

SECOND LEVEL OF APPEAL: RECONSIDERATION BY A QUALIFIED INDEPENDENT CONTRACTOR (QIC)

If you disagree with the MAC redetermination decision, you may request a reconsideration by a QIC. A reconsideration is a review of the redetermination decision.

Table 2. Reconsideration FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for reconsideration within **180 days** of receipt of the MRN or RA.

How do I file a request?	File your request **in writing** by following instructions provided on the MRN or RA. You may use the Medicare Reconsideration Request (Form CMS-20033), or any written document, so long as it contains the required elements listed in the MRN.
	Find more information about the requirements for requesting reconsideration on the Second Level of Appeal: Reconsideration by a QIC webpage.
	REMEMBER
	• **Clearly explain** why you disagree with the redetermination decision
	• You or your representative must include your **name and signature**
	• You should submit:
	  ◦ A copy of the RA or MRN
	  ◦ Any evidence noted in the redetermination as missing
	  ◦ Any other evidence relevant to the appeal
	  ◦ Any other useful documentation
	Documentation submitted after you file the reconsideration request may extend the QIC's decision timeframe.
	NOTE: Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late.

Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The **QIC** conducts the reconsideration, which is an independent review of the administrative record, including the redetermination. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals.

Table 2. Reconsideration FAQs and Answers (cont.)

Question	Answer
How long does it take to make a decision?	Generally, a QIC sends a decision to all parties within **60 days** of receipt of the request for reconsideration. If the QIC cannot complete its decision in the applicable timeframe, it will inform you of your rights and the procedures to escalate the case to OMHA. **NOTE:** Before escalating your appeal to OMHA, if you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays.

NOTE: On January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) launched a new Demonstration with Durable Medical Equipment (DME) Suppliers in DME MAC Jurisdictions C and D called the Formal Telephone Discussion Demonstration. The Demonstration provides selected suppliers who have filed a reconsideration request the opportunity to participate in a formal recorded telephone discussion with the DME QIC. Effective October 31, 2016, CMS expanded the Telephone Discussion Demonstration to include all appeal types not subject to another initiative.

THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE (ALJ) HEARING OR REVIEW BY OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA)

If you disagree with the reconsideration decision or wish to escalate your appeal because the reconsideration period passed, you may request one of two options under OMHA review: (1) an ALJ hearing or (2) an OMHA ALJ attorney adjudicator decision. This level of appeal gives you the opportunity—via telephone, video teleconference (VTC), or occasionally in person—to explain your position to an ALJ. If you don't wish to attend a hearing, you can ask OMHA (either an ALJ or attorney adjudicator) to make a decision based on evidence and the administrative record of the appeal (known as an on-the-record decision). The HHS OMHA, which is independent of CMS, is responsible for the Level 3 Medicare claims appeals.

Table 3. OMHA Review FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for an ALJ hearing, or a waiver of hearing, within **60 days** of receipt of the reconsideration decision letter or file a request with the QIC for OMHA review after the expiration of the reconsideration period.
How do I file a request?	File your request **in writing** by following instructions provided in the reconsideration letter. You may also request an ALJ hearing by completing the Request for ALJ Hearing or Review of Dismissal (Form OMHA-100) and the multiple claim attachment (Form OMHA-100A) as needed. These forms are new as of January 2017. If you do not want a telephone hearing, you may ask for an in-person or VTC hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis (there are exceptions to these procedures for unrepresented beneficiary appellants). If you would prefer to not have a hearing, you may ask for an on-the-record review by filling out the Waiver of RIght to an ALJ Hearing form (Form OMHA-104) and submitting it with the OMHA-100 form. If an on-the-record review is granted, an OMHA attorney adjudicator will issue a decision based on the information within the administrative record along with any evidence submitted with the request. Find more information about the requirements for requesting an ALJ hearing, including additional forms you may need, on the Office of Medicare Hearings and Appeals webpage. **REMEMBER** • You **must** send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. If you are requesting the case be escalated to the Council, you must send a copy of the request to all other parties **and** to the ALJ. • The ALJ sets hearing preparation procedures. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing.

Table 3. OMHA Review FAQs and Answers (cont.)

Question	Answer
Is there a minimum AIC requirement?	**Yes.** You may only request an ALJ hearing if a certain dollar amount remains in controversy following the QIC's decision. The Third Level of Appeal AIC Threshold is updated annually. Find out how the AIC amount is calculated on the OMHA FAQs webpage.
Who makes the decision?	The **ALJ or attorney adjudicator** makes the decision. If the OMHA cannot complete a decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Council. The ALJ or attorney adjudicator forwards the decision and case file to the Administrative QIC (AdQIC), which serves as the central manager for all OMHA Original Medicare claim case files. In certain situations, the AdQIC may refer the case to the Council on CMS' behalf. If no referral is made to the Council, and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim, according to the OMHA decision, within 30–60 days.
How long does it take to make a decision?	Due to a record number of appeal requests, there continues to be a delay in OMHA ALJ hearing assignments. OMHA remains committed to processing ALJ hearing requests in the order received and as quickly as possible, given pending requests and adjudicatory resources. OMHA prioritizes Part D prescription drug denial cases that qualify for expedited status and Medicare beneficiary issues. Additional delay can result from: • Appellant's failure to send notice of the hearing request to other parties • The discovery request process • Reconsideration-level escalations • Request for an in-person hearing • Submission of additional evidence not included with the hearing request If OMHA does not issue a decision within the applicable timeframe, you may ask OMHA to escalate the case to the Council. **NOTE:** New appeal requests are processed as quickly as possible. You will receive an Acknowledgement of Request letter after your case is entered in to the OMHA case tracking system. Find more information on these timeframes on the Office of Medicare Hearings and Appeals webpage. **NOTE:** As part of the efforts to reduce the outstanding number of ALJ hearing requests, OMHA implemented two pilot programs: Settlement Conference Facilitation (SCF) and Statistical Sampling Initiative. SCF is an alternative dispute resolution process that uses mediation principles. Statistical Sampling Initiative applies to appellants with a large volume of claim disputes.

FOURTH LEVEL OF APPEAL: REVIEW BY THE MEDICARE APPEALS COUNCIL (COUNCIL)

If you disagree with the ALJ or attorney adjudicator decision, or you wish to escalate your appeal because the OMHA decision timeframe passed, you may request a Council review. The HHS Departmental Appeals Board (DAB) Medicare Operations Division conducts the Council review.

Table 4. Council Review FAQs and Answers

Question	Answer
When must I file a request?	You must file your request for Council review within **60 days** of receipt of the ALJ's decision or after the OMHA decision timeframe expires.
How do I file a request?	File your request **in writing** by following the instructions provided by OMHA. You may also request a Council review by completing the Request for Review of ALJ Medicare Decision/Dismissal (Form DAB-101) or the electronic version accessible through the DAB E-File webpage. Find more information about the requirements for requesting a Council review following an OMHA decision on the Medicare Appeals Council webpage. **REMEMBER** • **Explain** which part of the OMHA decision you disagree with and your reasons for the disagreement • You **must** send a copy of the Council review request to all the parties included in OMHA's decision
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The Council makes the decision. If the Council cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to U.S. District Court. The Council forwards the decision and case file to the AdQIC, which serves as the central manager for all Council Original Medicare claim case files. If the Council decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim according to the Council's decision within 30–60 days.

Table 4. Council Review FAQs and Answers (cont.)

Question	Answer
How long does it take to make a decision?	Generally, the Council issues a decision within **90 days** from receipt of a request for review of an ALJ decision. If the Council review stems from an escalated appeal, then the Council has **180 days** from the date of receipt of the request for escalation to issue a decision. A decision may take longer due to a variety of reasons. If the Council does not issue a decision within the applicable timeframe, you may ask the Council to escalate the case to the judicial review level. If you are requesting escalation to U.S. District Court, a copy of the request must be sent to all other parties **and** to the Council.

FIFTH LEVEL OF APPEAL: JUDICIAL REVIEW IN U.S. DISTRICT COURT

If you disagree with the Council decision, or you wish to escalate your appeal because the Council ruling timeframe passed, you may request judicial review.

Table 5. Judicial Review in U.S. District Court FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for judicial review within **60 days** of receipt of the Council's decision or after the Council ruling timeframe expires.
How do I file a request?	The Council's decision (or notice of right to escalation) contains information on how to **file a claim in U.S. District Court**.
Is there a minimum AIC requirement?	**Yes.** You may only request judicial review if a certain dollar amount remains in controversy following the Council decision. The Fifth Level of Appeal AIC Threshold is updated annually.
Who makes the decision?	The **U.S. District Court** makes the decision.

TIPS FOR FILING AN APPEAL

Now that we have discussed the five levels in the claims appeals process, here are some best practices when filing an appeal:

- **Make all appeal requests in writing!**
- Starting at Level 1, consolidate as many similar claims as possible into one appeal
- File timely requests with the appropriate contractor
- Include a copy of the decision letter(s) or claim information issued at the previous level
- Include a copy of the demand letter(s) if appealing an overpayment determination
- Include all relevant supporting documentation with your first appeal request
- Include a copy of the Appointment of Representative (AOR) form if the requestor is not a party and is representing a provider/supplier/beneficiary
- Respond promptly to the contractor requests for documentation
- Sign your request for appeal

Find more information about the Medicare overpayment collection process in the Medicare Overpayments booklet.

APPEAL PROCESS SUMMARY

A summary of each appeal level is provided in Table 6.

Table 6. Appeal Process Summary

Level	Summary of review process	Who performs the review?	When must you request an appeal?	When should you get a decision?	AIC	Links to Forms
1st Level – Redetermination by a Medicare Administrative Contractor (MAC)	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No	CMS-20027 CMS-20031
2nd Level – Reconsideration by a Qualified Independent Contractor (QIC)	Document review of redetermination; submit any missing evidence or evidence relevant to the appeal	QIC	Up to 180 days after you receive MRN/RA	60 days	No	CMS-20033
3rd Level – Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)	May be an interactive hearing between parties or an on-the-record review	ALJ or attorney adjudicator	Up to 60 days after you receive notice of QIC decision or after expiration of the applicable QIC reconsideration timeframe if you do not receive a decision	May be delayed due to volume	Yes	OMHA-100 OMHA-100A OMHA-104
4th Level – Review by the Medicare Appeals Council (Council)	Document review of ALJ's decision (but you may request oral arguments)	Council	Up to 60 days after you receive notice of OMHA's decision or after expiration of the applicable OMHA decision timeframe if you do not receive a decision	90 days if appealing an OMHA decision or dismissal or 180 days if ALJ review time expired without an ALJ decision	No	DAB-101
5th Level – Judicial Review in U.S. District Court	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Council decision or after expiration of the applicable Council review timeframe if you do not receive a decision	No statutory time limit	Yes	No HHS form available

RESOURCES

For more information, refer to the resources in Table 7.

Table 7. Resources

Resource	Website
Appeals Laws, Regulations, and Guidance	Social Security Act, Section 1869 SSA.gov/OP_Home/ssact/title18/1869.htm 42 Code of Federal Regulations (Part 405, Subpart I) GPO.gov/fdsys/pkg/CFR-2016-title42-vol2/pdf/CFR-2016-title42-vol2-part405-subpartI.pdf Medicare Claims Processing Manual, Chapter 29 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
MAC Contact Information	CMS.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Medicare Appeals Council	HHS.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-council
Medicare Appeals Process	HHS.gov/about/agencies/omha/the-appeals-process
MLN Matters® Limiting the Scope of Review on Redeterminations or Reconsiderations of Certain Claims	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf
OMHA	HHS.gov/about/agencies/omha
OMHA Medicare Appellant Forum	HHS.gov/about/agencies/omha/about/special-initiatives/appellant-forums
Original Medicare Appeals	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
Part C Appeals	Medicare Managed Care Appeals & Grievances CMS.gov/Medicare/Appeals-and-Grievances/MMCAG Part C Appeals: Organization Determinations, Appeals & Grievances Web-Based Training (WBT) Course CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Table 7. Resources (cont.)

Resource	Website
Part D Appeals	Medicare Prescription Drug Appeals & Grievances CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev Part D Coverage Determinations, Appeals & Grievances WBT Course CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
QIC Formal Telephone Demonstration: Updated	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/QIC-Formal-Telephone-Demonstration-Revised-Fact-Sheet-–-November-18-2016v508.pdf
QICs	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Reopenings	Reopenings and Revisions of Claim Determinations and Decisions CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4147.pdf Correction of Minor Errors and Omissions Without Appeals CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf Medicare Claims Processing Manual, Chapter 34, Reopening and Revision of Claim Determinations and Decisions CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf
Settlement Effectuation Instructions for the Department of Health and Human Services' (DHHS) Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) Pilot	CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1588OTN.pdf Part A Specific Instructions CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1633OTN.pdf
U.S. District Courts	USCourts.gov/about-federal-courts/court-role-and-structure

Table 8. Hyperlink Table

Embedded Hyperlink	Complete URL
ALJ Hearing or Review of Dismissal OMHA-100	https://www.hhs.gov/sites/default/files/OMHA-100%20Request%20for%20Hearing%20or%20Review%20of%20Dismissal%200329.pdf
Appointment of Representative	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf
Correction of Minor Errors and Omissions Without Appeals	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf
DAB E-File	https://dab.efile.hhs.gov
Expanded the Telephone Discussion Demonstration	https://www.c2cinc.com/Telephone-Demonstration
Fifth Level of Appeal AIC Threshold	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html
First Level of Appeal: Redetermination by a Medicare Contractor	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html
Formal Telephone Discussion Demonstration	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/QIC-Formal-Telephone-Demonstration-Revised-Fact-Sheet-—November-18-2016v508.pdf
Medicare Appeals Council	https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-council
Medicare Claims Processing Manual, Chapter 29	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
Medicare Overpayments Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243389.html
Medicare Reconsideration Request CMS-20033	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf
Medicare Redetermination Request CMS-20027	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf
Medicare.gov Original Medicare Appeals	https://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals.html

Table 8. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Multiple Claim Attachment OMHA-100A	https://www.hhs.gov/sites/default/files/OMHA-100A-Multiple-Claim-Attachment.pdf
Office of Medicare Hearings and Appeals	https://www.hhs.gov/about/agencies/omha
OMHA FAQs	https://www.hhs.gov/about/agencies/omha/filing-an-appeal/faqs/requesting-an-alj-hearing
Original Medicare (Fee-For-Service) Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
Request for Review of ALJ Medicare Decision/Dismissal DAB-101	https://www.hhs.gov/sites/default/files/dab/divisions/dab101.pdf
Second Level of Appeal: Reconsideration by a QIC	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Settlement Conference Facilitation	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation
Statistical Sampling Initiative	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/statistical-sampling
Third Level of Appeal AIC Threshold	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html
Transfer of Appeal Rights CMS-20031	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20031.pdf
Waiver of Right to an ALJ Hearing OMHA-104	https://www.hhs.gov/sites/default/files/OMHA-104_Waiver_of_Right_to_an_ALJ_Hearing%200328.pdf

APPENDIX V
MEDICARE FRAUD AND ABUSE

mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

AVOIDING MEDICARE FRAUD & ABUSE: A ROADMAP FOR PHYSICIANS

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare). Many of the laws discussed apply to all Federal Health Care Programs (including Medicaid and Medicare Advantage).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

TABLE OF CONTENTS

INTRODUCTION

Most physicians strive to work ethically, provide high-quality medical care to their patients, and submit proper claims for payment. Trust is at the core of the physician-patient relationship. The Federal Government also places enormous trust in physicians. Medicare and other Federal health care programs rely on physicians' medical judgment to treat patients with appropriate, medically necessary services. Federal health care programs rely on physicians to submit accurate claims when requesting payment for Medicare-covered health care items and services.

The presence of some dishonest health care professionals who exploit Federal health care programs for illegal personal gain creates the need for laws that combat fraud and abuse and ensure appropriate quality medical care.

This booklet helps physicians understand how to comply with these Federal laws by identifying "red flags" that could lead to potential liability in criminal, civil, and administrative enforcement actions.

During their careers, physicians frequently encounter the following three types of business relationships that may raise fraud and abuse concerns:

1. Relationships with payers
2. Relationships with fellow physicians and other providers
3. Relationships with vendors

These key relationships, and other issues addressed in this document, apply to all physicians, regardless of specialty or practice setting.

FRAUD AND ABUSE LAWS

The following Federal fraud and abuse laws apply to physicians:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Social Security Act, which includes the Exclusion Statute and the Civil Monetary Penalties Law (CMPL)
- United States Criminal Code

FRAUD AND ABUSE IN MEDICARE PART C, PART D, AND MEDICAID

In addition to Medicare Part A and Part B, the Medicare Part C and Part D and Medicaid programs prohibit the fraudulent conduct addressed by these laws. For more information, look for the Web-Based Training (WBT) courses at the Medicare Learning Network® (MLN) Learning Management System (LMS).

Violating these laws may result in non-payment of claims, Civil Monetary Penalties (CMPs), exclusion from all Federal health care programs (including Medicare), and criminal and civil liability. This booklet briefly summarizes each law below and includes hyperlinks to the text of the laws in Table 2.

Government agencies, including the U.S. Department of Justice (DOJ), the U.S. Department of Health & Human Services (HHS), the HHS Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), enforce these laws.

Federal False Claims Act (FCA)

The civil FCA protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who **knowingly** submits, or **causes** the submission of, a false or fraudulent claim to the Federal Government.

The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. **No proof of specific intent to defraud is required to violate the civil FCA.**

An example may be a physician who knowingly submits claims to Medicare for medical services not provided.

Civil penalties for violating the FCA may include fines of up to **three** times the amount of damages sustained by the Government as a result of the false claims, plus up to $21,916 (in 2017) per false claim filed.

Additionally, under various Federal criminal statutes, individuals or entities may face criminal penalties for submitting false claims, including fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS makes it a crime to **knowingly and willfully** offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS.

NOTE: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

SAFE HARBORS AND CMPS

Refer to the Revisions to Safe Harbors Under the AKS & CMPs to learn about recent updates to the existing safe harbor regulations and CMP rules.

Civil penalties for violating the AKS may include penalties of up to $74,792 (in 2017) per kickback plus **three** times the amount of the kickback. Criminal penalties for violating the AKS may include fines, imprisonment, or both.

If certain types of arrangements satisfy safe harbor regulations, they may not violate the AKS.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from referring for certain designated health services payable by Medicare or Medicaid to an **entity** where the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement, unless an exception applies.

Penalties for physicians who violate the Stark Law may include fines, CMPs up to $24,253 (in 2017) for each service, repayment of claims, and potential exclusion from all Federal health care programs.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to either:

- Defraud any health care benefit program, or
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusion Statute

Under the Exclusion Statute, the OIG must exclude from participation in all Federal health care programs individuals and entities convicted of any of the following:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

OIG also has discretion to impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacturing, distributing, prescribing, or dispensing of controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

OIG GENERAL EXCLUSION AUTHORITIES

Refer to the OIG's General Exclusion Authorities to learn about changes to the regulations.

Excluded providers may not participate in Federal health care programs for a designated period. An excluded provider may not bill Federal health care programs (including, but not limited to, Medicare, Medicaid, and State Children's Health Insurance Program [SCHIP]) for services he or she orders or performs. Additionally, an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded individual or entity must seek reinstatement; reinstatement is not automatic.

The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE).

Civil Monetary Penalties Law (CMPL)

The Civil Monetary Penalties Law authorizes CMPs for a variety of health care fraud violations. The CMPL provides for different amounts of penalties and assessments based on the type of violation. CMPs may assess up to **three** times the amount claimed for each item or service or up to **three** times the amount of remuneration offered, paid, solicited, or received. Violations supporting CMPL actions include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- Presenting a claim you know, or should know, is for an item or service for which Medicare will not pay
- Violating the AKS

CMP INFLATION ADJUSTMENT

Each year, the Federal Government adjusts all CMPs for inflation. These adjusted amounts apply to civil penalties assessed after August 1, 2016, and violations after November 2, 2015. Refer to 45 CFR 102.3 for the yearly inflation adjustments.

PHYSICIAN RELATIONSHIPS WITH PAYERS

The U.S. health care system relies heavily on third-party payers. Third-party payers often pay the majority of beneficiary medical bills and include commercial insurers and the Federal and State Governments. **When the Federal Government covers items or services rendered to Medicare beneficiaries, Federal fraud and abuse laws apply.** Many similar State laws apply to your provision of care under State-financed programs and to private-pay patients. The issues discussed here may apply to the care you provide to all insured patients.

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. You exert significant influence over what services your patients receive. You control the documentation describing what services they actually received, and your documentation serves as the basis for claims sent to insurers for services provided. Generally, the Federal Government pays claims based solely on representations in the claims documents.

When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal. Examples of improper claims include:

- Billing for medically unnecessary services
- Billing for services not provided
- Billing for services performed by an improperly supervised or unqualified employee
- Billing for services performed by an employee excluded from participation in the Federal health care programs
- Billing for services of such low quality that they are virtually worthless
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery

Physician Documentation

Maintain accurate and complete medical records and documentation of the services you provide, and ensure your documentation supports submitted claims for payment. **Good documentation ensures your patients receive appropriate care from you and other providers who may rely on your records for patients' medical histories.**

The Medicare Program may review beneficiaries' medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare billing.

ACCURACY OF MEDICAL RECORD DOCUMENTATION

For more information on physician documentation, refer to the Evaluation and Management Services guide, Complying With Medical Record Documentation Requirements fact sheet, and an OIG video on the Importance of Documentation.

Upcoding

Medicare pays for many physician services using Evaluation and Management (E/M) codes. New patient visits generally require more time than follow-up visits for established patients. Medicare pays E/M codes for new patients at higher reimbursement rates than E/M codes for established patients. An example of upcoding is billing an established patient follow-up visit using a higher level E/M code, such as a comprehensive new patient office visit.

Another example of E/M upcoding is the misuse of modifier -25. Modifier -25 allows additional payment for an E/M service provided on the same day as a separate procedure or service. Upcoding occurs when a provider uses modifier -25 to claim payment for a medically unnecessary E/M service, a service not distinctly separate from the other service provided, or a service not above and beyond the care usually associated with the procedure.

PHYSICIAN RELATIONSHIPS WITH OTHER PROVIDERS

Anytime a health care business offers you something for free or below fair market value, ask yourself, **"Why?"**

Physician Investments in Health Care Business Ventures

Some physicians who invest in health care business ventures with outside parties (for instance, imaging centers, laboratories, equipment vendors, or physical therapy clinics) refer more patients to those parties than physicians who do not invest. These business relationships can improperly influence or distort physician decision-making and result in the improper steering of a patient to a particular therapy or service where a physician has a financial interest.

Excessive and medically unnecessary referrals cost the Federal Government and Medicare beneficiaries and can expose beneficiaries to harm from unnecessary services. Many of these investment relationships have serious legal risks under the AKS and Stark Law.

If you are invited to invest in a health care business whose services you might order or where you might refer your patients, ask yourself the following questions. If you answer "yes" to any of them, you should carefully consider the reasons for your investment.

- Is the investment interest offered for a nominal capital contribution from you?
- Is the ownership share larger than your share of the aggregate capital contributions made to the venture?
- Is the venture promising you high rates of return for little or no financial risk?
- Is the venture, or any potential business partner, offering to loan you the money to make your capital contribution?

PHYSICIAN INVESTMENTS

For more information on physician investments, refer to the OIG's:

- Special Fraud Alert: Joint Venture Arrangements
- Special Fraud Alert: Physician-Owned Entities
- Special Advisory Bulletin: Contractual Joint Ventures
- Supplemental Compliance Program Guidance for Hospitals

PHYSICIAN RELATIONSHIPS

For more information on physician relationships with:

- **Fellow providers**, refer to the OIG's Compliance Program for Individual and Small Group Physician Practices
- **Hospitals**, refer to the OIG's Supplemental Compliance Program Guidance for Hospitals
- **Nursing homes**, refer to the OIG's Supplemental Compliance Program Guidance for Nursing Facilities

- Are you promising or guaranteeing you will refer patients or order items or services from the venture?
- Are you more likely to refer more patients for the items and services provided by the venture because you made the investment?
- Does the venture have sufficient capital from other sources to fund its operations?

Physician Recruitment

Hospitals may provide a recruitment incentive to induce a physician to relocate to the hospital's geographic area, join its medical staff, and establish a practice that helps serve that community's medical needs. Often, such recruitment efforts fill a legitimate "clinical gap" in a medically underserved area where attracting physicians may be difficult in the absence of financial incentives.

However, in some communities, especially ones with multiple hospitals, hospitals fiercely compete for patients. To gain referrals, some hospitals may offer illegal incentives to you or to the established physician practice you join in the hospital's community. This means the competition for your loyalty can cross the line into an illegal arrangement with legal consequences for you and the hospital.

A hospital may pay you a fair market-value salary as an employee or pay you fair market value for specific services rendered to the hospital as an independent contractor. However, the hospital may **not** offer you money, provide you free or below-market rent for your medical office, or engage in similar activities designed to influence your referral decisions. **Admit your patients to the hospital best suited to care for their particular medical conditions or to the hospital your patient selects based on his or her preference or insurance coverage.**

As noted, if a hospital or physician practice recruits you as a physician to the community, it may offer a recruitment package. Unless you are a hospital employee, you cannot negotiate for benefits in exchange for an implicit or explicit promise that you will admit your patients to a specific hospital or practice setting. Seek knowledgeable legal counsel if a prospective business relationship requires you to admit patients to a specific hospital or practice group.

PHYSICIAN RELATIONSHIPS WITH VENDORS

Free Samples

Many drug and biologic companies provide physicians with free samples they may give to patients free of charge. It is legal to give these samples to your patients for free, but it is illegal to sell them. The Federal Government prosecutes physicians for billing Medicare for free samples. If you choose to accept samples, you need reliable systems in place to safely store the samples and ensure samples remain separate from your commercial stock.

Relationships With the Pharmaceutical and Medical Device Industries

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty to their products. As a practicing physician, you may have opportunities to work as a consultant or promotional speaker for the drug or device industry. For every financial relationship offered, evaluate the link between the services you can provide and the compensation you will receive. Test the appropriateness of any proposed relationship by asking yourself the following questions:

INDUSTRY RELATIONSHIPS

For more information on distinguishing between legitimate and questionable industry relationships, refer to the OIG's Compliance Program Guidance for Pharmaceutical Manufacturers.

- Does the company **really** need **your** particular expertise or input?
- Does the company's monetary compensation represent a **fair**, **appropriate**, and **commercially reasonable** exchange for your services?
- Is it possible the company's monetary compensation is for **your loyalty** so you prescribe its drugs or use its devices?

If your contribution is your time and effort or your ability to generate useful ideas and the payment you receive is fair market value compensation for your services without regard to referrals, then, depending on the circumstances, you may legitimately serve as a bona fide consultant. **If your contribution is your ability to prescribe a drug, use a medical device, or refer patients for particular services or supplies, the potential consulting relationship likely is one you should avoid as it could violate fraud and abuse laws.**

Transparency in Physician-Industry Relationships

Although some physicians believe free lunches, subsidized trips, and gifts do not affect their medical judgment, research shows these types of privileges can influence prescribing practices.

Federal Open Payments Program

The Federal Open Payments Program highlights financial relationships among physicians, teaching hospitals, and drug and device manufacturers. Drug, device, and biologic companies must publicly report nearly all gifts or payments made to physicians.

The Federal Open Payments Program requires manufacturers of pharmaceuticals or medical devices to publicly report payments to physicians and teaching hospitals. CMS posts Open Payments data on June 30 each year, including payments or other transfers of value and ownership or investment interest reports.

Publicly available information about you includes:

- Activities such as speaking engagements
- Educational materials like text books or journal reprints
- Entertainment
- Gifts
- Meals
- Participation in a paid advisory board
- Travel expenses

PHARMACEUTICAL AND MEDICAL DEVICE INDUSTRIES CODES OF ETHICS

Both the pharmaceutical industry through the Pharmaceutical Research and Manufacturers of America (PhRMA) and the medical device industry through the Advanced Medical Technology Association (AdvaMed) adopted codes of ethics regarding relationships with health care professionals. For more information, visit the PhRMA Code on Interactions With Health Care Professionals and the AdvaMed Code of Ethics.

CMS does not require physicians to register with, or send information to, Federal Open Payments. However, CMS encourages your help to ensure accurate information by doing the following:

- Keeping records and using the Open Payments Mobile for Physicians app to track payments and other transfers of value you receive from applicable manufacturers and applicable Group Purchasing Organizations (GPOs) (visit Apps for Tracking Assistance for instructions on downloading the app)
- Registering with the Open Payments system and subscribing to the electronic mailing list for Program updates

- Reviewing the information manufacturers and GPOs submit on your behalf
- Working with manufacturers and GPOs to settle data issues about your Open Payments profile

CMS closely monitors this process to ensure integrity in the data posted. For more information, visit Open Payments Data webpage.

Conflict-of-Interest Disclosures

Many of the relationships discussed in this booklet are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may be obligated to disclose their existence. Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as States, universities, and the National Institutes of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics.

If you are uncertain whether a conflict exists, apply the "newspaper test" and ask yourself if you would want the arrangement to appear on the front page of your local newspaper.

Continuing Medical Education (CME)

You are responsible for your CME to maintain State licensure, hospital privileges, and board certification. Drug and device manufacturers sponsor many educational opportunities for physicians. **It is important to distinguish between CME educational sessions and marketing sessions by a drug or device manufacturer.** If speakers recommend using a drug when there is no FDA approval or using a drug on children when the FDA has approved only adult use, independently seek out the empirical data that support these recommendations.

NOTE: Although physicians may prescribe drugs for off-label uses, it is illegal under the Federal Food, Drug, and Cosmetic Act for drug manufacturers to promote off-label drug use.

FDA BAD AD PROGRAM

Advertisements and other promotional materials for drugs, biologics, and medical devices must be truthful, not misleading, and limited to approved uses. The FDA requests physicians' assistance in identifying misleading advertisements through its Bad Ad Program. If you spot advertising violations, report them to the FDA by calling 877-RX-DDMAC (877-793-3622) or by emailing BadAd@fda.gov.

Watch the What To Do About Misleading Drug Ads video for more information.

COMPLIANCE PROGRAMS FOR PHYSICIANS

Physicians treating Medicare beneficiaries should establish a compliance program. Establishing and following a compliance program helps physicians avoid fraudulent activities and helps them submit accurate claims. The following seven components provide a solid basis for a physician practice compliance program:

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond appropriately to detected offenses and develop corrective action
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines

COMPLIANCE PROGRAMS FOR PHYSICIANS

For more information on compliance programs for physicians, visit the OIG's Compliance webpage or watch this Compliance Program Basics video.

RESOURCES

Where to Go for Help

When considering whether or not to engage in a particular billing practice; enter into a particular business venture; or pursue any employment, consulting, or other personal services relationship, evaluate the arrangement for potential compliance problems. The following list of possible resources may help you:

MEDICAL IDENTITY THEFT

For more information, refer to the Medical Identity Theft & Medicare Fraud brochure.

Legal Counsel

- Experienced health care lawyers can analyze your issues and provide a legal evaluation and risk analysis of the proposed venture, relationship, or arrangement.
- The Bar Association in your State may maintain a directory of attorneys in your area who practice in the health care field.

YOU CAN HELP FIGHT FRAUD – REPORT IT!

The OIG Hotline accepts tips and complaints from all sources on potential fraud, waste, and abuse. View instructional videos about the OIG Hotline operations, as well as reporting fraud to OIG.

Professional Organizations

- Your State or local medical society may be a good resource for issues affecting physicians and may keep listings of health care lawyers in your area.
- Your specialty society may have information on additional risk areas specific to your type of practice.

CMS

- Medicare Administrative Contractor (MAC) medical directors are a valuable source of information on Medicare coverage policies and appropriate billing practices. Contact your MAC for more information.
- CMS issues advisory opinions to parties seeking advice on the Stark Law. For more information on how to request a CMS advisory opinion and links to published CMS advisory opinions, visit the CMS Advisory Opinions webpage.

OIG

- For more information on OIG compliance recommendations and discussions of fraud and abuse risk areas, refer to OIG's Compliance Program Guidance. Visit OIG's Compliance Education Materials for more information.
- OIG issues advisory opinions to parties who seek advice on the application of the Anti-Kickback Statute, Civil Monetary Penalties Law, and Exclusion Statute. For more information on how to request an OIG advisory opinion and links to published OIG advisory opinions, visit the OIG Advisory Opinions webpage.

What to Do if You Think You Have a Problem

If you think you are in a problematic relationship or have been following billing practices you now realize are wrong:

- Immediately cease filing the problematic bills
- Seek knowledgeable legal counsel
- Determine what money you collected in error from patients and from the Federal health care programs and report and return overpayments
- Undo the problematic investment by freeing yourself from your involvement
- Disentangle yourself from the suspicious relationship
- Consider using OIG's or CMS' self-disclosure protocols, as applicable

OIG Provider Self-Disclosure Protocol

The OIG Provider Self-Disclosure Protocol is a vehicle for physicians to voluntarily disclose self-discovered evidence of potential fraud. The protocol gives providers the opportunity to avoid the costs and disruptions associated with a Federal Government-directed investigation and civil or administrative litigation. For more information, visit the OIG Self-Disclosure Information webpage.

CMS Self-Referral Disclosure Protocol (SRDP)

The SRDP enables health care providers and suppliers to self-disclose actual or potential violations of the Stark Law. You can report using the SRDP on the Physician Self-Referral Law webpage.

What to Do if You Have Information About Fraud and Abuse Against Federal Health Care Programs

If you have information about fraud and abuse against Federal health care programs, use the OIG Fraud Hotline to report that information to the appropriate authorities. The Hotline allows the option of reporting anonymously. You may also contact your local MAC.

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Email: HHSTIPS@oig.hhs.gov

Online: Forms.oig.hhs.gov/hotlineoperations/index.aspx

Medicare.gov/Fraud

Mail: U.S. Department of Health & Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

Resources on the Web

For more information about the OIG and fraud, visit the OIG website. For more information regarding preventing, detecting, and reporting fraud and abuse, as well as other Medicare information, refer to the resources listed in Table 1. Table 2 provides hyperlinks to applicable laws.

Table 1. Fraud and Abuse Resources

Resource	Website
Can Someone Change My CPT Codes?	Medscape.com/viewarticle/872465 **NOTE:** To access this program, you will need to create a free account.
CMS Fraud and Abuse Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf
CMS Fraud Prevention Toolkit	CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
Frequently Asked Questions (FAQs): Medicare Fraud and Abuse	Questions.CMS.gov/faq.php?id=5005&rtopic=1887
Help Fight Medicare Fraud	Medicare.gov/Forms-Help-and-Resources/Report-Fraud-and-Abuse/Fraud-and-Abuse.html
Medicaid Program Integrity Education	CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html
Medicaid Program Integrity: Safeguarding Your Medical Identity Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
Medicare Learning Network® Electronic Mailing Lists: Keeping Health Care Professionals Informed Listing	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243324.html
MLN Provider Compliance	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Email Updates	OIG.HHS.gov/Contact-Us
World of Medicare WBT	Learner.MLNLMS.com

Table 2. Applicable Laws

Statutory References	Website
Anti-Kickback Statute 42 United States Code (USC) Section 1320a-7b(b)	GPO.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
Civil Monetary Penalties Law 42 USC Section 1320a-7a	GPO.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
Criminal Health Care Fraud 18 USC Section 1347	GPO.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf
Exclusion Statute 42 USC Section 1320a-7	GPO.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf
Federal Civil False Claims Act 31 USC Sections 3729–3733	GPO.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf
False, Fictitious, or Fraudulent Claims 18 USC Section 287	GPO.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap15-sec287.pdf
Physician Self-Referral Law (Stark Law) 42 USC Section 1395nn	GPO.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Regulatory Safe Harbors 42 Code of Federal Regulations (CFR) Section 1001.952	GPO.gov/fdsys/pkg/CFR-2016-title42-vol5/pdf/CFR-2016-title42-vol5-sec1001-952.pdf

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
45 CFR 102.3	https://www.ecfr.gov/cgi-bin/text-idx?SID=f3da2968a38d247521cada756ad2ad4f&mc=true&node=pt45.1.102&rgn=div5#se45.1.102_13
AdvaMed Code of Ethics	https://www.advamed.org/issues/code-ethics
AKS	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Apps for Tracking Assistance	https://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Apps-for-Tracking-Assistance.html
Civil FCA	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf
Civil Monetary Penalties Law	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
CMS Advisory Opinions	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/advisory_opinions.html
Compliance Education Materials	https://oig.hhs.gov/compliance/101
Compliance Program Basics	https://www.youtube.com/watch?v=bFT2KDTEjAk
Compliance Program for Individual and Small Group Physician Practices	https://oig.hhs.gov/authorities/docs/physician.pdf
Compliance Program Guidance	https://oig.hhs.gov/compliance/compliance-guidance
Compliance Program Guidance for Pharmaceutical Manufacturers	https://oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf
Complying With Medical Record Documentation Requirements	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909160.html
Contact Your MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Criminal Health Care Fraud	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf
Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Exclusion Statute	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf
Importance of Documentation	https://www.youtube.com/watch?v=1M7kKGqSa14
Learning Management System	https://learner.mlnlms.com
List of Excluded Individuals/Entities	https://oig.hhs.gov/exclusions/exclusions_list.asp
Medical Identity Theft & Medicare Fraud	https://oig.hhs.gov/fraud/medical-id-theft/OIG_Medical_Identity_Theft_Brochure.pdf
OIG Advisory Opinions	https://oig.hhs.gov/compliance/advisory-opinions
OIG Hotline Operations	https://www.youtube.com/watch?v=Wlsnd1DYG6Y
OIG's Compliance	https://oig.hhs.gov/compliance
OIG Self-Disclosure Information	https://oig.hhs.gov/compliance/self-disclosure-info
OIG's General Exclusion Authorities	https://oig.hhs.gov/exclusions/files/1128b7exclusion-criteria.pdf
OIG Website	https://oig.hhs.gov
Open Payments Data	https://openpaymentsdata.cms.gov
PhRMA Code on Interactions With Health Care Professionals	http://www.phrma.org/codes-and-guidelines/code-on-interactions-with-health-care-professionals
Physician Self-Referral Law	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Physician Self-Referral Law Webpage	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
Reporting Fraud to OIG	https://www.youtube.com/watch?v=nH7p30j7dOw
Revisions to Safe Harbors Under the AKS & CMPs	https://www.gpo.gov/fdsys/pkg/FR-2016-12-07/pdf/2016-28297.pdf
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations
Special Advisory Bulletin: Contractual Joint Ventures	https://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Special Fraud Alert: Joint Venture Arrangements	https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html
Special Fraud Alert: Physician-Owned Entities	https://oig.hhs.gov/fraud/docs/alertsandbulletins/2013/pod_special_fraud_alert.pdf
Supplemental Compliance Program Guidance for Hospitals	https://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf
Supplemental Compliance Program Guidance for Nursing Facilities	https://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf
What To Do About Misleading Drug Ads	https://www.medscape.com/viewarticle/754890

APPENDIX W
MEDICAID CHART

Jurisdiction	Covered by Medicaid	PA Enrolled in Medicaid	Reimbursement Rate	Supervision*
Alabama	Yes	Yes	80%; 100% for labs and injectables	State law
Alaska	Yes	Yes	85%	State law
Arizona	Yes	Yes	90%	State law
Arkansas	No	No	100%	State law
California	Yes	Yes	100%	State law
Colorado	Yes	Yes	100%	State law
Connecticut	Yes	Yes	90%	State law
Delaware	Yes	enroll for crossover claims and for ordering and referring	100%	State law
District of Columbia	Yes	No (except for mental health and rehab services)	100%	State law
Florida	Yes	Yes	80%, 84% for children 29 y.o. and younger; 100% with on site supervision and co-signature	State law or for 100% reimbursement on site plus co-signature
Georgia	Yes	Yes	90%	State law
Hawaii	Yes	No	100%	Direct provider/physician observation or contact with the patient
Idaho	Yes	Yes	65-85% per contract	State law
Illinois	Yes	Yes	100%	State law
Indiana	Yes	No	100%	State law
Iowa	Yes	No; enrolled as ordering and referring	100%; 75% in hospital and 85% in nursing facilities	State law
Kansas	Yes	Yes	75%	State law
Kentucky	Yes	Yes	75%	State law
Louisiana	Yes	Yes	80%, immunizations, EPSDT, vision & hearing 100%	State law
Maine	Yes	Yes, enrolled as servicing provider	100%	State law
Maryland	Yes	Yes	100%	State law
Massachusetts	Yes	No	85% (bill with HN modifier)	State law
Michigan	Yes	Yes	100%	State law
Minnesota	Yes	Yes	90% for enrolled PAs or 65% for non-enrolled PAs	State law
Mississippi	Yes	Yes	90%	State law
Missouri	Yes	Yes	100%	State law

Jurisdiction	Covered by Medicaid	PA Enrolled in Medicaid	Reimbursement Rate	Supervision*
Montana	Yes	Yes	90%; 100% of the fee for immunizations, family planning, injectables, lab and pathology services, radiology, cardiography and echocardiography, and services to members under age 21 (i.e., well-child EPSDT services).	State law
Nebraska	Yes	Yes	100%	State law
Nevada	Yes	Yes	69-88% depending on the service	State law
New Hampshire	Yes	Yes	100%	State law
New Jersey	Yes	No	100%	State law for managed care**
New Mexico	Yes	Yes	100%	State law
New York	Yes	Yes	100%	State law
North Carolina	Yes	Yes	100%	State law
North Dakota	Yes	Yes	75%	State law
Ohio	Yes	Yes	85%; 100% if physician provided distinct/identifiable part of service or if service is usually provided by medical personnel below the physician assistant level of education	State law
Oklahoma	Yes	Yes	100%	State law
Oregon	Yes	Yes	100%	State law
Pennsylvania	Yes	No	100%	State law
Rhode Island	Yes	Yes	Fee-for-Service – 100%	State law
South Carolina	Yes	Yes	100% 75% for Medicare crossover claims	State law (the state takes “direct supervision” to mean that a supervising physician must be accessible when the services being billed are provided; and is responsible for all services rendered, fees charged and reimbursements received
South Dakota	Yes	Yes	90%; 100% for	State law

Jurisdiction	Covered by Medicaid	PA Enrolled in Medicaid	Reimbursement Rate	Supervision*
			laboratory services, radiological services, immunizations, and supplies	
Tennessee	Yes	Yes	**United** – Usually 80%, but can vary by contract **Amerigroup** – 100% **BlueCare/TennCareSelect** – 100%	**United** - state law **Amerigroup** - state law **BlueCare/TennCareSelect** – A supervising physician is not required to be on site when a service is rendered and supervision may take place several days or even weeks after. Supervision may merely involve a review of an individual's medical record.
Texas	Yes	Yes	92%; 100% for laboratory services, x-ray services, and injections. Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician's provider identifier may continue this billing arrangement.	State law
Utah	Yes	Yes	100%	State law
Vermont	Yes	Yes	90%	State law
Virginia	Yes	No	100%	State law
Washington	Yes	Yes	100%	State law
West Virginia	Yes	Yes – Only in RHC or FQHC – otherwise bill under the physician	100%	The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
Wisconsin	Yes	Yes	90%; 100% for HealthCheck screens, injections,	State law + Physician assistants are required to complete

Jurisdiction	Covered by Medicaid	PA Enrolled in Medicaid	Reimbursement Rate	Supervision*
			immunizations, lab handling fees, and select diagnostic procedures.	the Declaration of Supervision for Nonbilling Providers
Wyoming	Yes	Yes	100%	State law (The state explains that the term “direct supervision” does NOT indicate a locational necessity but rather indicates a direct responsibility.

*Language in place of “state law” is quoted from a manual or official document and is in addition to, or clarifying, state law

**Supervision for fee-for-service must be personal (in the room)

APPENDIX X
STATE MEDICAID OFFICE CONTACT INFORMATION

State Medicaid Contacts

Alabama

Stephanie Azar
Commissioner
State of Alabama, Alabama Medicaid Agency
501 Dexter Avenue, PO Box 5624
Montgomery, AL 36103-5624
(334) 242-5600
NAMD Region: III

Alaska

Margaret Brodie
Director, Health Care Services
State of Alaska, Department of Health and Social Services
4501 Business Park Boulevard Building L
Anchorage, AK 99504
(907) 334-2520
NAMD Region: I

Arizona

Thomas Betlach
Director
State of Arizona, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034
(602) 417-4711
NAMD Region: I

California

Mari Cantwell
Medicaid Director
State of California, Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814
(916) 440-7400
NAMD Region: I

Arkansas

Dawn Stehle
Deputy Director for Health and Medicaid Director
State of Arkansas, Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608
(501) 682-8740
NAMD Region: III

Colorado

Gretchen Hammer
Medicaid Director
State of Colorado, Department of Health Care Policy and Financing; Medicaid & Child Health Plan (CHP+)
1570 Grant Street
Denver, CO 80203-1818
(303) 866-5929
NAMD Region: I

Connecticut

Kate McEvoy
State Medicaid Director
State of Connecticut, Department of Social Services
55 Farmington Avenue
Hartford, CT 06105
(860) 424-5383
NAMD Region: IV

District of Columbia

Claudia Schlosberg *Medicaid Director*
District of Columbia
One Judiciary Square 441 4th Street, N.W.
Washington, DC 20001
(202) 442-9075
NAMD Region: IV

Georgia

Blake Fulenwider
Chief of the Medicaid Assistance Plans
State of Georgia, Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303
(404) 651-8681
NAMD Region: III

Delaware

Stephen Groff
Medicaid Director
State of Delaware, Department of Health and Social Services
1901 N. Dupont Highway, PO Box 906
Lewis Building
New Castle, DE 19720
(302) 255-9626
NAMD Region: IV

Florida

Beth Kidder
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308
(850) 412-4007
NAMD Region: III

Hawaii

Judy Mohr Peterson
Medquest Division Administrator
State of Hawaii, Department of Human Services
601 Kamokila Blvd, Room 518 PO Box 700190
Kapolei, HI 96709-0190
(808) 692-8050
NAMD Region: I

Idaho

Matt Wimmer
Administrator
State of Idaho, Department of Health and Welfare
450 West State Street PTC Building, 10th Floor
Boise, ID 83705
(208) 334-1804
NAMD Region: I

Illinois

Teresa Hursey
Acting Administrator
State of Illinois, Department of Healthcare and Family
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001
(217) 782-2570
NAMD Region: II

Indiana

Allison Taylor
Director of Medicaid
State of Indiana, Family and Social Services Administration
402 West Washington Street
Room W461, MS 25
Indianapolis, IN 46204
(317) 234-8725
NAMD Region: II

Iowa

Mike Randol
Medicaid Director
State of Iowa, Department of Human Services
100 Army Post Road
Des Moines, IA 50315
(515) 256-4621
NAMD Region: II

Kansas

Jon Hamdorf
Medicaid Director
State of Kansas, Department of Health and Environment
900 SW Jackson Avenue Suite 900
Topeka, KS 666612
(785) 296-0461
NAMD Region: II

Kentucky

Stephen P. Miller
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky, Cabinet for Health and Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621
(502) 564-4321
NAMD Region: III

Louisiana

Jen Steele
Medicaid Director
State of Louisiana, Department of Health and Hospitals
628 North 4th Street
Baton Rouge, LA 70802
(225) 342-9240
NAMD Region: III

Maryland

Dennis Schrader
Medicaid Director
State of Maryland, Department of Health
201 West Preston Street, Room 525
Baltimore, MD 21201
(410) 767-4139
NAMD Region: IV

Maine

Stefanie Nadeau
Director, Office of MaineCare Services
State of Maine, Department of Health and Human Services
221 State Street
Augusta, ME 04333
(207) 287-2674
NAMD Region: IV

Massachusetts

Daniel Tsai
Medicaid Director
Commonwealth of Massachusetts, Department of Health and Human Services, Office of Medicaid
1 Ashburton Place, 11th Floor Room 1109
Boston, MA 02108
(617) 573-1770
NAMD Region: IV

Michigan

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State of Michigan, Department of Community Health
400 South Pine Street
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NAMD Region: II

Minnesota

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Medicaid Director
State of Minnesota, Department of Human Services
540 Cedar Street, PO Box 64983
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NAMD Region: II

Mississippi

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State of Mississippi, Department of Human Services, Division of Medicaid
550 High Street Suite 1000
Walter Sillers Building
Jackson, MS 39201-1325
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NAMD Region: III

Missouri

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State of Missouri, Department of Social Services
615 Howerton Court, PO Box 6500
Jefferson City, MO 65102
(573) 751-6922
NAMD Region: II

Montana

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State of Montana, Department of Public Health and Human Services
111 North Sanders, PO Box 4210
Helena, MT 59604
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NAMD Region: I

Nebraska

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State of Nebraska, Department of Health and Human Services
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PO Box 95026
Lincoln, NE 68509-5026
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NAMD Region: II

Nevada

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State of Nevada, Department of Health and Human Services
Division of Health Care Financing and Policy
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Carson City, NV 89710
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New Hampshire

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State of New Hampshire, Department of Health and Human Services
129 Pleasant Street
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NAMD Region: IV

New Jersey

Meghan Davey
Director
State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services
7 Quakerbridge Plaza, PO Box 712
Trenton, NJ 08625-0712
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NAMD Region: IV

New Mexico

Nancy Smith-Leslie
Director
State of New Mexico, Medical Assistance Division Department of Human Services
PO Box 2348
Santa Fe, NM 87504-2348
(505) 827-6253
NAMD Region: III

New York

Jason Helgerson
State Medicaid Director, Deputy Commissioner
State of New York, Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237
(518) 474-3018
NAMD Region: IV

North Carolina

Dave Richard
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State of North Carolina, Department of Health and Human Services
1985 Umstead Drive, 2501 Mail Service Center
Raleigh, NC 27699-2501
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NAMD Region: III

North Dakota

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State of North Dakota, Department of Human Services
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NAMD Region: II

Ohio

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Oklahoma

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NAMD Region: III

Oregon

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Pennsylvania

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Rhode Island

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Executive Office, Health and Human Services
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South Carolina

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NAMD Region: III

South Dakota

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NAMD Region: II

Tennessee

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NAMD Region: III

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Utah

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Vermont

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West Virginia

West Virginia

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Acting Commissioner
State of West Virginia, Department of Health and Human Resources
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Wisconsin

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APPENDIX Y
STATE WORKERS' COMPENSATION OFFICE CONTACT INFORMATION

State Workers Compensation Contacts

ALABAMA
Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131
(334) 242-2868 or 1-800-528-5166

ALASKA
Department of Labor & Workforce Development
Division of Workers' Compensation
1111 West 8th Street, Room 307
P. O. Box 115512
Juneau, AK 99811-5512
(907) 465-2790 or 1-877-783-4980

ARIZONA
Industrial Commission of Arizona
Claims Division
800 West Washington Street
Phoenix, AZ 85007
(602) 542-4661

ARKANSAS
Arkansas Workers' Compensation Commission
324 Spring Street
P. O. Box 950
Little Rock, AR 72203-0950
(501) 682-3930 or 1-800-622-4472

CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
455 Golden Gate Avenue, 2nd Floor
San Francisco, CA 94102-7014
(415) 703-5020 or 1-800-736-7401

COLORADO
Department of Labor and Employment
Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202-3660
(303) 318-8700 or 1-888-390-7936

CONNECTICUT
Workers' Compensation Commission
Capitol Place
21 Oak Street
Hartford, CT 06106
(860) 493-1500 or 1-800-223-9675 (Toll-Free in Connecticut)

DELAWARE
Department of Labor
Division of Industrial Affairs
Office of Workers' Compensation
4425 North Market Street
Wilmington, DE 19802
(302) 761-8200

DISTRICT OF COLUMBIA
Department of Employment Services
Labor Standards Bureau
Office of Workers' Compensation
4058 Minnesota Avenue, N.E., 3rd Floor
Washington, DC 20019
(202) 671-1000

FLORIDA
Department of Financial Services
Division of Workers' Compensation
200 East Gaines Street
Tallahassee, FL 32399-0318
1-800-342-1741

GEORGIA
Georgia State Board of Workers' Compensation
270 Peachtree Street, NW
Atlanta, GA 30303-1299
(404) 656-3875 or 1-800-533-0682

GUAM
Workers' Compensation Commission
414 West Soledad Avenue
Suite 400 (fourth Floor), GCIC Building
Hagatna, GU 96910
(671) 300-4571
*mailing address
P. O. Box 9970
Tamuning, GU 96931
(671) 475-7033

HAWAII
Department of Labor and Industrial Relations
Disability Compensation Division
Princess Keelikolani Building
830 Punchbowl Street, Room 209
P. O. Box 3769
Honolulu, HI 96812-3769
(808) 586-9161

IDAHO
Industrial Commission
700 South Clearwater Lane
P. O. Box 83720
Boise, ID 83720-0041
(208) 334-6000

ILLINOIS
Illinois Workers' Compensation Commission
100 West Randolph Street
Suite 8-200
Chicago, IL 60601
(312) 814-6611 or 1-866-352-3033 (Toll-Free in Illinois)

INDIANA
Workers' Compensation Board of Indiana
402 West Washington Street
Room W-196
Indianapolis, IN 46204
(317) 232-3808 or 1-800-824-2667 (Outside Indianapolis)

IOWA
Iowa Workforce Development
Division of Workers' Compensation
150 Des Moines Street
Des Moines, IA 50309
mailing address:
1000 East Grand Avenue
Des Moines, IA 50319-0209
(515) 725-4120 or 800-645-4583

KANSAS
Department of Labor
Division of Workers' Compensation
401 SW Topeka Blvd, Suite 2
Topeka, KS 66603-3105
(785) 296-4000 option 9 or (800) 332-0353 option 9

KENTUCKY
Kentucky Labor Cabinet
Department of Workers' Claims
657 Chamberlin Avenue
Frankfort, KY 40601
(502) 564-5550 or 1-800-554-8601

LOUISIANA
Louisiana Workforce Commission
Office of Workers' Compensation
1001 North 23rd Street
P.O. Box 94040
Baton Rouge, LA 70804-9040
(225) 342-3111

MAINE
Workers' Compensation Board
442 Civil Center Drive, Suite 100
27 State House Station
Augusta, ME 04333-0027
(207) 287-3751 or 1-888-801-9087 (Toll-Free in Maine)

MARYLAND
Workers' Compensation Commission
10 East Baltimore Street, 4th Floor
Baltimore, MD 21202
(410) 864-5100 or 1-800-492-0479 (Outside Baltimore)

MASSACHUSETTS
Executive Office of Labor and Workforce Development
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
(617) 727-4900 or 1-800-323-3249

MICHIGAN
Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
2501 Woodlake Circle
Okemos, MI 48864
mailing address:
P. O. Box 30016
Lansing, MI 48909
1-888-396-5041

MINNESOTA
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155
(651) 284-5005 or 1-800-342-5354

MISSISSIPPI
Workers' Compensation Commission
1428 Lakeland Drive
P. O. Box 5300
Jackson, MS 39296-5300
(601) 987-4200 or 1-866-473-6922

MISSOURI
Department of Labor and Industrial Relations
Division of Workers' Compensation
3315 West Truman Blvd., Room 131
P. O. Box 58
Jefferson City, MO 65102-0058
(573) 751-4231 or 1-800-775-2667

MONTANA
Department of Labor and Industry
Employment Relations Division
Workers' Compensation Claims Assistance Bureau
1805 Prospect Avenue
P. O. Box 8011
Helena, MT 59604-8011
(406) 444-6543

NEBRASKA
Workers' Compensation Court
P. O. Box 98908
Lincoln, NE 68509-8908
(402) 471-6468 or 1-800-599-5155

NEVADA
Department of Business & Industry
Division of Industrial Relations
400 W. King Street, Suite 400
Carson City, NV 89703
(775) 684-7260

NEW HAMPSHIRE
Workers' Compensation Division
Department of Labor
95 Pleasant Street
Concord, NH 03301
(603) 271-3176 or 1-800-272-4353

NEW JERSEY
Department of Labor and Workforce Development
Division of Workers' Compensation
P. O. Box 381
Trenton, NJ 08625-0381
(609) 292-2515

NEW MEXICO
Workers' Compensation Administration
2410 Centre Avenue, SE
P. O. Box 27198
Albuquerque, NM 87125-7198
(505) 841-6000 or 1-800-255-7965

NEW YORK
Workers' Compensation Board
20 Park Street
Albany, NY 12207
(518) 462-8880 or (877) 632-4996
mailing address:
P.O. Box 5205
Binghamton, NY 13902-5205

NORTH CAROLINA
Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603
mailing address:
1240 Mail Service Center
Raleigh, NC 27699-1240
(919) 807-2501 or 1-800-688-8349

NORTH DAKOTA
Workforce Safety and Insurance
1600 East Century Avenue, Suite 1
Bismarck, ND 58503-0644
(701) 328-3800 or 1-800-777-5033

OHIO
Bureau of Workers' Compensation
30 West Spring Street
Columbus, OH 43215-2256
(614) 728-5416 or 800-644-6292

OKLAHOMA
Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, OK 73105
(405) 522-8600 or 1-800-522-8210

OREGON
Workers' Compensation Division
350 Winter Street, NE
P.O. Box 14480
Salem, OR 97309-0405
(503) 947-7585 or 1-800-452-0288

PENNSYLVANIA
Bureau of Workers' Compensation
Department of Labor and Industry
1171 S. Cameron Street, Rm. 324
Harrisburg, PA 17104-2501
(717) 772-4447 or 1-800-482-2383

PUERTO RICO
Industrial Commission
P.O. Box 364466
San Juan, PR 00924
(787) 781-0545

RHODE ISLAND
Department of Labor & Training
Division of Workers' Compensation
1511 Pontiac Ave., Building 71-1, 1st Floor
P. O. Box 20190
Cranston, RI 02920-0942
(401) 462-8100

SOUTH CAROLINA
Workers' Compensation Commission
1333 Main Street, Suite 500
P. O. Box 1715
Columbia, SC 29202-1715
(803) 737-5700

SOUTH DAKOTA
Department of Labor and Regulation
Division of Labor & Management
123 W. Missouri Avenue
Pierre, SD 57501-2291
(605) 773-3681

TENNESSEE
Department of Labor and Workforce Development
Division of Workers' Compensation
220 French Landing Drive
Nashville, TN 37243-1002
(615) 532-4812 or 1-800-332-2667

TEXAS
Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Ste. 100
Austin, TX 78744-1609
(512) 804-4000 or 1-800-252-7031

UTAH
Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P. O. Box 146610
Salt Lake City, UT 84114-6610
(801) 530-6800 or 1-800-530-5090

VERMONT
Department of Labor
Workers' Compensation Division
5 Greenmountain Drive
P.O. Box 488
Montpelier, VT 05601-0488
(802) 828-2286 or 1-800-734-2286

VIRGINIA
Workers' Compensation Commission
333 E. Franklin Street
Richmond, VA 23219
1-877-664-2566

VIRGIN ISLANDS
Department of Labor
Workers' Compensation Administration
2353 Kronprindsens Gade
Charlotte Amalie, St. Thomas, VI 00802
(340) 776-3700 or 800-809-8477

WASHINGTON
Department of Labor and Industries
Insurance Services Division
7273 Linderson Way, SW
Tumwater, WA 98501-5414
(360) 902-5800 or 1-800-547-8367
mailing address:
P. O. Box 44000
Olympia, WA 98504-4000

WEST VIRGINIA
Offices of the Insurance Commission
1124 Smith Street
P.O. Box 50540
Charleston, WV 25305-0540
(304) 558-3386 or 1-888-879-9842

WISCONSIN
Department of Workforce Development
Workers' Compensation Division
201 East Washington Avenue
P. O. Box 7901
Madison, WI 53707-7901
(608) 266-1340

WYOMING
Department of Workforce Services
Workers' Compensation Division
1510 East Pershing Boulevard
Cheyenne, WY 82002
(307) 777-5476

APPENDIX Z
RULING ON PA-OWNED RHC BILLING

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gayle Pugh, PA,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1317

Decision Number CR3420

Date: October 17, 2014

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor Novitas Solutions, denied the revalidation enrollment application of Petitioner, Gayle Pugh, as a physician assistant because Petitioner indicated that she was a sole practitioner on her application. Because I conclude that Petitioner serves as a physician assistant with the rural health clinic (RHC) Petitioner owns, I reverse CMS's determination.

I. Background and Procedural History

Petitioner is a physician assistant for and the owner of Buna Medical Clinic (Buna), an RHC located in Buna, Texas. Petitioner Declaration (P. Decl.) at 1-3; P. Exhibit (Ex.) 1, at 1, 8. Petitioner enrolled in Medicare as a physician assistant. CMS Ex. 2; P. Exs. 2, at 1; 10, at 5. As the owner and authorized representative of Buna, she enrolled Buna in Medicare Part B as a RHC. P. Decl. at 1-3; P. Ex. 10, at 2-4, 8-9, 14; CMS Ex. 11. Petitioner states her Medicare Part B services as a physician assistant are billed under Buna's PTAN and NPI. P. Decl. at 3.

In a March 1, 2013 letter, Novitas notified Petitioner that she had to revalidate her enrollment information. CMS Ex. 1. The letter was sent to Petitioner as a physician assistant, not to Buna as a RHC, although the letter inconsistently cited Petitioner's NPI and Buna's PTAN. CMS Ex. 1, at 1-2. Petitioner submitted a revalidation enrollment application.

On January 9, 2014, Novitas issued an initial determination denying Petitioner's enrollment application under 42 C.F.R. § 424.530(a)(1) because, as a Medicare supplier, Petitioner did not meet CMS enrollment requirements. Specifically, Novitas determined that because Petitioner is a physician assistant she "cannot be enrolled into Medicare as a Sole Proprietor. [She] must report an employer to receive payment for services rendered in Part B Medicare." The letter informed Petitioner that she could either submit a corrective action plan (CAP) within 30 days from the date of the letter or exercise her right to request reconsideration within 60 days from the date of the letter. CMS Ex. 3.

Petitioner requested reconsideration twice, once on February 25, 2014, in a letter signed by her billing manager, and again on March 6, 2014, in a letter signed by Petitioner. CMS Exs. 4, 5. Novitas treated the February 25, 2014 letter as a CAP and did not process it as it "was not signed by the individual provider." CMS Ex. 7. Novitas considered Petitioner's March 6, 2014 reconsideration request. On June 2, 2014, a Novitas hearing officer issued a decision upholding the original revalidation denial. In the decision, the hearing officer stated that,

> Novitas Solutions is unable to process the revalidation application that was received on March 20, 2013 since the Medicare file is set up as a physician assistant sole proprietor. Per 42 § CFR 410.74 . . . physician assistant's services are covered by Medicare Part B only if the services furnished are billed by the employer of a physician assistant. Since the Medicare file is only for the physician assistant and there is no employer tied to this file, the denial of the revalidation application was correct.

CMS Ex. 8, at 2.

On June 9, 2014, the Civil Remedies Division received Petitioner's request for an administrative law judge hearing. The case was assigned to me for hearing and decision. In response to my June 25, 2014 Acknowledgment and Pre-Hearing Order, CMS filed a pre-hearing brief and motion for summary judgment (CMS Br.), and 11 proposed exhibits (CMS Exs. 1-11). CMS did not list any proposed witnesses. Petitioner filed a declaration in opposition (P. Decl.) and 10 proposed exhibits (P. Exs. 1-10).

II. Decision on the Record

In the absence of objection, I admit CMS Exs. 1-5, 7-11 and P. Exs. 1-10 into the record. I do not admit CMS Ex. 6 because, despite what CMS's exhibit list indicates, CMS Ex. 6 is identical to CMS Ex. 5 and, therefore, repetitive.

My Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would be necessary only if the opposing party requested an opportunity to cross-examine a witness. Order ¶¶ 8-10. CMS did not submit written direct testimony for any proposed witnesses. Petitioner signed and submitted a document entitled Petitioner's Declaration in Opposition to Respondent's Motion for Summary Judgment. CMS neither objected to this document nor sought to cross-examine Petitioner based on this document. Order ¶¶ 7-9. Consequently, I will issue a decision on the record. Order ¶ 11.

III. Issue

The general issue is whether CMS had a legitimate basis to deny Petitioner's revalidation of enrollment as a physician assistant under 42 C.F.R. § 424.530(a)(1). The specific issue is whether CMS correctly determined that Petitioner is not qualified to be enrolled as a physician assistant because she is not employed and her employer does not bill for her services. 42 C.F.R. § 410.74(a)(2)(v).[1]

IV. Jurisdiction

I have jurisdiction to decide this issue. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

V. Findings of Fact, Conclusions of Law, and Analysis[2]

In order to maintain Medicare billing privileges, suppliers enrolled in the Medicare program must periodically revalidate their enrollment by submitting an enrollment application to CMS. 42 C.F.R. § 424.515. CMS may deny a supplier's enrollment

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[1] Petitioner, who appears pro se, appears to be somewhat confused regarding the actual issue in the case, discussing whether Buna was in compliance with Medicare enrollment requirements, not whether she is qualified to be enrolled as a physician assistant. P. Decl. at 1. Although Petitioner's argument may not be focused, her statements regarding the nature of the relationship between her ownership of Buna and her employment by Buna effectively address the issue I must decide.

[2] My findings of fact and conclusions of law in this case are set forth in italics and bold font.

application in the Medicare program if a supplier is found not to be in compliance with Medicare enrollment requirements applicable to the type of supplier enrolling. 42 C.F.R. § 424.530(a)(1).

For Medicare program purposes, physician assistants are suppliers. 42 C.F.R. §§ 400.202 (definition of *Supplier*); 498.2 (definition of *Supplier*). A "physician assistant" is an individual "who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary [of HHS] may prescribe in regulations." 42 U.S.C. § 1395x(aa)(5)(A). Physician assistant services may be billed as physician services. 42 U.S.C. § 1395x(s)(2)(H)(i), K(i). However, "Medicare Part B covers physician assistants' services only if [the services] . . . are billed by the employer of a physician assistant." 42 C.F.R. § 410.74(a) and (a)(2)(v); *see also* 42 C.F.R. § 410.150(b)(15).

1. Petitioner is both the owner of and the physician assistant for Buna, a rural health clinic.

Neither party disputes that Petitioner owns Buna. Petitioner states:

> Petitioner, Gayle Pugh, PA, enrolled in Medicare A, personally, as a provider, and was approved. Petitioner, Gayle Pugh, PA was issued Medical Provider #8A3714, UPIN #S53556. Petitioner, as the owner and authorized representative of Buna Medical Clinic, also enrolled Buna Medical Clinic, as a sole proprietor in the Medicare B program. Buna Medical Clinic was approved and issued Medical Provider #67-3844, UPIN #00726U. Gayle Pugh is the owner of the facility and is also employed by the facility as the facilities provider of Medical services.

P. Decl. at 3. Petitioner asserts that her Medicare Part B services are billed through her employer, Buna, and her Medicare Part A services are billed through her own transaction numbers. P. Decl. at 1, 3. Enrollment documents filed by Petitioner in 2003 show that she submitted two Medicare enrollment applications, one for Buna and one for herself as a physician assistant. CMS Ex. 9. The first is Petitioner's "Practitioner Enrollment Application," reflecting Buna Medical as a "legal business name," giving Buna's location, stating that Petitioner practices at Buna, and that Medicare payment is to be sent to Buna. Petitioner signed the certification statement for this enrollment application on February 28, 2003. CMS Ex. 9, at 1-14. The second enrollment application is a supplier application for Buna Medical Clinic, and reflects that Buna is organized as a "sole proprietor." It reflects that Petitioner is Buna's owner and the individual with

management control. Buna is identified as a RHC. Petitioner signed the certification statement as the "authorized official for Buna on February 27, 2003. CMS Ex. 9, at 16, 17, 29, 41; P. Ex. 1. Buna was assigned PTAN 00726U on March 31, 2003. P. Ex. 10, at 8. Petitioner signed a Medicare "Participating Physician or Supplier Agreement" on behalf of Buna as "Pa/Owner" on April 4, 2003, which was received by Medicare and effectuated. P. Ex. 10, at 9, 14; CMS Ex. 11. Nothing in these enrollment applications conflicts with Petitioner's statement that she functions as both the owner of Buna and the physician assistant of Buna as its "facilities provider." Further, CMS also determined that Buna met the requirements to be a RHC. P. Ex. 10, at 3.

Petitioner's declaration that she is an employee of Buna and that Buna bills for her Medicare Part B services is supported by the enrollment documents in evidence indicating that she and Buna were separately enrolled in Medicare. From Petitioner's statements, I find that she is both the owner of Buna and serves as the physician assistant for Buna.

> ***2. Petitioner's position as owner and the physician assistant for Buna, a RHC, satisfies the requirement in 42 C.F.R. § 410.74(a)(2)(v) that she be an employee of Buna because the specific regulations governing RHCs permits this.***

The only disputed issue in this case is whether Petitioner is employed as a physician assistant and her employer bills the Medicare program for her services. Based on the regulatory provisions related to RHCs, I conclude that Petitioner's ownership position in Buna, taken with the fact that Petitioner serves as the physician assistant for Buna, is sufficient for Petitioner to meet the employment and billing requirements in 42 C.F.R. § 410.74(a)(2)(v).

As mentioned above, Petitioner declares in opposition to CMS's position that she is the owner of Buna, a sole proprietorship, and that she is also an employee of Buna. P. Decl. at 3. Petitioner also asserts that Buna is enrolled in the Medicare program as an RHC, and that Buna bills the Medicare program for Medicare Part B services that Petitioner provides. P. Decl. at 3.

CMS states that it denied revalidation of Petitioner's PTAN because "although Petitioner applied to participate in Medicare as a physician's assistant, she failed to include an employer in her revalidation application." CMS Br. at 1. Despite the fact that CMS states in its exhibit list that it was filing Petitioner's 2013 revalidation application as CMS Ex. 10, CMS instead filed as CMS Ex. 10 an "Application Record Data Report" that is

essentially unreadable. Thus, there is no substantive exhibit admitted into the record that supports CMS's argument.[3] However, even if Petitioner did not list Buna as her employer, this would not change the analysis below.

This case presents a situation where there is a minor conflict between the general regulatory provision involving physician assistant enrollment requirements, and the statutory and regulatory provisions meant to permit RHCs to operate in areas of the country that are underserved.

A RHC is defined by regulation as "a clinic that is located in a rural area designated as a shortage area . . ." 42 C.F.R. § 491.2. A "shortage area" is defined by regulation as "a defined geographic area designated by the Department [of HHS] as having either a shortage of personal health services . . . or a shortage of primary medical care manpower." 42 C.F.R. § 491.2. The purpose of establishing special rules for RHCs is to better address the problem of areas underserved by health care providers.

Physician assistants [and nurse practitioners] play a central role to the functions of RHCs. In order for RHCs to be enrolled in the Medicare program: the RHC must employ a physician assistant [or a nurse practitioner]; the RHC must have a physician assistant [or nurse practitioner] present for at least half the RHC's hours of operation; and the RHC may designate a physician assistant to ensure the execution of the operating policies of the RHC. 42 U.S.C. § 1395x(aa)(2)(F), (J), (K)(iii). There are also a variety of other requirements in the regulations; however, once they have been met and CMS has approved a provider agreement, the RHC may bill Medicare for physician assistant services. 42 C.F.R. §§ 405.2402, 405.2414. Most significant for this decision, "[t]he physician assistant . . . member of the [RHC] staff may be the owner or an employee of the clinic . . . ." 42 C.F.R. § 491.8(a)(1), (3).

Petitioner's position is that she owns and is employed by Buna. However, Petitioner has also stated Buna is a sole proprietorship. The difficulty in this case arises from Petitioner's choice of ownership of Buna (i.e., a sole proprietorship). It is unlikely that Petitioner can be, as she asserts, an employee of Buna. This is because sole proprietorships have essentially the same legal personality as its owner. *Ideal Lease Service, Inc. v. Amoco Production Co., Inc.*, 662 S.W.2d 951, 952 (Tex. 1983) ("Blue Streak Welding Service was, in law and in fact, one and the same as Thompson because a sole proprietorship has a legal existence only in the identity of the sole proprietor."); *see also* Black's Law Dictionary (9th ed. 2009) (defining "sole proprietorship" as "[a]

[3] CMS also states that although Petitioner has been enrolled in Medicare since 2003, her initial enrollment was in error because her initial Medicare enrollment applications all reflect that she was a sole proprietor and no employer was listed to bill for the services she furnished. CMS Br. at 4; CMS Ex. 9, at 5.

business in which one person owns all the assets, owes all the liabilities, and operates in his or her personal capacity."). Although CMS believes that the inquiry into Petitioner's enrollment ends with this conclusion, it does not.

It is significant that "[r]ural health clinic staffs must also include one or more physician assistants" and "[t]he physician assistant . . . member of the staff may be the owner or an employee of the clinic . . . ." 42 C.F.R. § 491.8(a)(1), (3). From the context of the two quoted provisions above, it is clear that the "[t]he physician assistant" who may be the owner of the RHC is the same as the physician assistant who is a member of the RHC's staff. Further, the regulation permits that physician assistant to be either the owner or an employee. It would create an absurdity, and be counter to Congress' efforts to foster rural health care using physician assistants, to interpret 42 C.F.R. § 410.74(a)(2)(v) in a manner that would ensure that no physician assistant on the staff of a RHC could ever own the RHC. Rather, a more reasonable interpretation would be to permit a physician assistant who owns and is on the staff of a RHC to be enrolled as a physician assistant if the RHC bills for the services provided by that physician assistant. *See* 42 C.F.R. §§ 405.2402, 405.2414.

CMS argue that the Novitas hearing officer found that denial of Petitioner's revalidation application was correct because a physician assistant cannot enroll in Medicare as a sole proprietor since the physician assistant requires a supervising physician to bill for physician assistant services and Petitioner's revalidation application did not include an employing physician. CMS Br. at 2-3. However, the reconsideration determination did not say this and, if it had, it would have been incorrect. 42 C.F.R. § 410.74(a)(2)(v). The hearing officer in fact found that physician assistant services are covered by Medicare Part B only if the services furnished are billed by the physician assistant's "employer"; it does not state that the employer must be a physician.[4] CMS Ex. 8, at 2.

VI. Conclusion

Petitioner is a physician assistant who owns and is on the staff of an enrolled RHC. The RHC bills for the Medicare Part B services Petitioner provides. Therefore, Petitioner satisfies the requirement that physician assistant services be billed by an employer.

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[4] CMS's position that a physician assistant must be employed by a physician is also not accurate in regard to the regulations that apply to RHCs. The regulations require that a RHC be under the medical direction of a physician and that the physician supervise the RHC's health care staff, which must include a physician assistant or nurse practitioner. However, the physician does not need to be on the RHC's staff or be its owner to accomplish this. Instead, the physician may provide physician services "under agreement" with the RHC. 42 C.F.R. §§ 491.7; 491.8(a)(2).

For the reasons stated above, I reverse CMS's determination to deny Petitioner's revalidation application.

Scott Anderson
Administrative Law Judge

APPENDIX AA1
EHRs AND PAs:
A WHITE PAPER

Electronic Health Records and PAs: A White Paper

Executive Summary

Integration and inclusion of PAs (physician assistants) in electronic health records (EHRs) is essential to achieve comprehensive care for individuals, better health for populations, and reduced healthcare costs. This can be achieved by addressing the EHR needs of PAs both in the design and development of EHR software, and during the readiness planning and implementation of EHR systems at clinics, hospitals, nursing facilities, health systems, and all healthcare settings.

EHRs should be designed to contribute to transparency and measure the contribution of patient care provided by PAs. Methods of measuring the contribution of services provided by PAs should be incorporated into the functionality of EHRs. This identification of professional work is important for clinical assessment, practice improvement, measuring productivity and care contribution, and management of population health.

EHRs must also be functional and have efficient workflows to gain provider acceptance and promote optimal patient care. Design-inefficiency for PAs and collaborating physicians may inhibit acceptance and adoption of EHRs, lead to noncompliance with regulations and institutional policies, and adversely affect patient care and health promotion.

EHRs and PAs

The electronic health record (EHR) is transforming healthcare with the goals of achieving more coordinated care for individuals and better health for populations. When appropriately designed and implemented, the value of EHRs has been demonstrated to improve quality, increase patient safety, improve operational efficiencies, provide cost savings, and improve patient experience and satisfaction (Healthcare Information and Management Systems Society, 2009).

To achieve these benefits, EHRs must be fully functional and operational for all designated healthcare professionals, including PAs (physician assistants). PAs are integral members of the healthcare team who provide care that would otherwise be delivered by physicians. There are PA-specific EHR needs in the areas of functionality, care attribution, transparency, and regulatory compliance. Currently accounting for about 10 percent of the healthcare provider workforce, the Bureau of Labor and Statistics (2015) projects a 30 percent increase in employment of PAs from 2014 to 2024. Due to the contribution of PAs to the provision of high-quality healthcare and the need to ensure efficient team practice, EHRs should be designed with specific functionality considerations for PAs. Optimal EHR functionality is essential for quality improvement, enhanced patient outcomes, ensuring accurate medical and legal documentation, compliance, transparency, research, and incentive-based payment programs.

To accomplish these goals, EHR developers must consider the needs of PAs from the inception of software design. EHR vendors have historically focused on physician and nursing end-users when designing systems. Many vendors employ physicians and/or nurses to help either guide development or provide subject matter expertise at the front-end of development.

Key PA attributes might be overlooked due to lack of awareness by these particular subject matter experts. Development flaws and oversights are often difficult to correct once the system is fully designed and implemented. The needs of end users of EHRs should be contemplated and reflected in system design and implementation to mitigate safety risks, achieve full functionality, and realize maximum benefits of use (Institute of Medicine [IOM], 2012). PAs should be included as part of the team that is assembled to guide design, build, test, implement, and support EHRs.

Accuracy and Transparency

Authorship attributes the origin or creation of a particular unit of information to a specific individual or entity acting at a particular time. When there are multiple authors or contributors to a document, all signatures should be retained so that each individual's contribution is unambiguously identified. Some EHR systems allow more than one individual to add text to the same progress note entry or flow sheet. If the EHR does not have functionality to enable both providers to document and sign, it may be impossible to verify that actual service provider or the amount of work performed by each provider (Integrity of the healthcare Record: Best Practices for EHR Documentation 2013 update http://library.ahima.org/doc?oid=300257#.WYjSxlWGOpq).

EHRs should be able to track the contribution of every clinician who provides professional services to patients. Because of "incident to", shared visit billing and different models of delivering team-based care, the contribution of a PA's services may be unaccounted by traditional measures such as billing claims, relative value units or volume of services rendered. EHRs should design methods of measuring the contribution of services provided by PAs to ensure transparency in healthcare. This identification of professional work is important for clinical assessment, practice improvement, measuring productivity and care contribution, and management of population health.

Quality and Safety

Ensuring patient safety and healthcare quality is essential to improving individual and population health and reducing healthcare costs. Accurate attribution of patients, treatments, and diagnostic tests to a rendering provider is needed for self-assessment and quality improvement. In addition, to improve patient safety, the Office of the National Coordinator for Health Information Technology (2016) recommends that ordering providers be identified on all test orders and reports, be notified of results, and have result notifications remain in inboxes until addressed. In order to improve patient safety and quality outcomes, EHRs need to ensure that orders and test results are appropriately assigned to the ordering PA.

Resource Utilization and Reimbursement

An essential component of cost-effective care is accurate attribution of costs and the resources expended for treatment to the responsible clinician. Attribution is needed for accurate, actionable data to result in reduced spending and efficient use of resources (Centers for Medicare and Medicaid Services [CMS], 2016). In addition, assignment of responsibility for cost is increasingly important as CMS and private payers reimburse based on quality, episode-based

payment models, and cost-savings incentives. In order to achieve accurate reimbursement and promote cost containment measures, it is essential that EHRs:

- attribute costs to the health professional who rendered the service and/or an ordering professional,
- measure contribution to care delivery for non-reimbursed services (e.g. computerized order entry, patient care documentation, diagnostic review and follow-up, and patient communications),
- and, identify care provided by PAs during "incident to" billing, shared visit billing, and billing under a collaborating physician for Medicare, Medicaid, and commercial insurers.

Compliance and Operability

EHRs should be capable of complying with federal, state, and facility policies and regulations. For example, a requirement for a physician co-signature on a specific PA order should be a potential function of an EHR system. However, there should not be an automatic system default that because a physician co-signature is necessary on a particular order that all PA orders require a physician co-signature. That misinterpretation can lead to unintended consequences of unnecessary work, which can undermine provider acceptance of EHRs, increase work and costs, and potentially result in patient harm (Jones et al., 2011). An EHR should also ensure the co-signature of a physician does not override the attribution of services by a PA.

EHR operability and functionality considerations for PAs are particularly important for avoidance of fraud and abuse. The Office of Inspector General (2013) recommends EHR safeguards to avoid fraud, which include user logs and controls to validate claims with rendering provider profiles to avoid submission of false claims by physicians when PAs are involved in shared care but physician participation or supporting documentation is missing. EHRs also need to safeguard against the ability to change the authorship of a document to ensure an accurate medical-legal document and prohibit fraud, and a physician should not have the ability to edit a PA's note as they would be able to do for a resident or fellow.

Conclusion

PAs are a critically important component to the delivery of efficient, high quality healthcare services. There are PA-specific issues that should be acknowledged to ensure effective EHR functionality, attribution, transparency, and regulatory compliance. Addressing the EHR needs of PAs is important both in the design and development of EHR software, and during the readiness planning and implementation of EHR systems at clinics, hospitals, nursing facilities, health systems, and all healthcare settings. Full integration and inclusion of PAs in EHR systems is essential to achieve comprehensive care for individuals, better health for populations, and reduced healthcare costs.

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References

Bureau of Labor Statistics. (2015, Dec. 17). Occupational outlook handbook: Physician assistants. Retrieved from https://www.bls.gov/ooh/healthcare/physician-assistants.htm

Centers for Medicare and Medicaid Services. (2016, Dec. 23). Episode-based cost measure development for the Quality Payment Program. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Episode-Based-Cost-Measure-Development-for-the-Quality-Payment-Program.pdf

Healthcare Information and Management Systems Society. (2009). The value of electronic health records. Retrieved from http://www.himssehra.org/docs/ValueEHRs.pdf

Institute of Medicine. (2012). *Health IT and patient safety: Building safer systems for better care*. Washington, DC: The National Academies Press.

Jones, S. S., Koppel, R., Ridgely, M. S., Palen, T. E., Wu, S., Harrison, M.I. (2011, Aug.) Guide to reducing unintended consequences of electronic health records: AHRQ Publication No. 11-0105-EF. Prepared by RAND Corporation.

Office of Inspector General. (2013, Dec.). Not all recommended fraud safeguards have been implemented in hospital EHR. Retrieved from https://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf

Office of the National Coordinator for Health Information Technology. (2016, Nov.). Safety assurance factors for EHR resilience: Test results reporting and follow-up. Retrieved from https://www.healthit.gov/safer/sites/safer/files/guides/safer_test_results_reporting.pdf

APPENDIX AA2
EHR BEST PRACTICES CHECKLIST

Best Practices Checklist for Your EHR System

Optimal PA Utilization of Electronic Health Records

- ❑ There is someone in the organization with whom a PA can speak regarding questions or concerns about the design, implementation or functionality of the electronic health record (EHR) system.
- ❑ All professional services delivered by a PA are captured by the EHR.
- ❑ All professional services delivered by a PA can be tracked and attributed to the PA via the EHR, even when those services are billed under a physician's name.
- ❑ A PA is able to obtain a report from the EHR system for all of the services he or she delivered.
- ❑ If a physician co-signature is required, the professional services a PA provided and documented will be attributed to the PA provider of service.
- ❑ The EHR system does not contain requirements that are more restrictive or prohibitive than federal or state law (e.g. co-signature requirements or limitations on writing orders/prescriptions) unless specified by practice or facility policy.
- ❑ If a PA practices in more than one specialty, the PA will have access to EHR functionality appropriate to his or her scope of practice, credentialing and privileges for each specialty.
- ❑ The requirement of a physician co-signature on one type of an order does not create an automatic requirement for a physician co-signature on other types of orders (e.g., a requirement for a physician co-signature on a controlled substances order does not necessitate a physician co-signature requirement on all medication orders).
- ❑ A PA can view changes, corrections, and/or addendums to the patient's medical record made by him or her and other health professionals with access to the medical record.
- ❑ The EHR system can be modified based on feedback from PAs and other health professionals, to improve use, operability, and compliance.

APPENDIX AA3
EHR BEST PRACTICES FOR VENDORS

Electronic Health Records and PAs: Best Practices for EHR Vendors

PAs (physician assistants) are state-licensed medical professionals who deliver medical and surgical services, as authorized by state law. PAs are integral members of the healthcare team and need access to electronic health records (EHRs) to effectively deliver care to patients.

PA Facts

- More than 115,000 PAs practice medicine and prescribe medication in all 50 states, the District of Columbia, U.S. territories, and the uniformed services. The profession is expected to grow . . .
- In 2016, PAs were responsible for an estimated 475 million patient visits.
- The Affordable Care Act recognized PAs as one of three primary care providers (along with nurse practitioners and physicians) and empowered PAs to lead patient-centered medical teams.
- PAs are individually credentialed and privileged by hospitals to deliver a wide range of medical and surgical services.
- In the office setting, PAs often have their own schedule and panel of patients, and practice with a high degree of autonomy.

EHR Best Practices

An increased focus on team-based care will require health providers to utilize EHRs to achieve optimal care coordination. However, some EHRs are currently designed in a way that limits effective use by care providers such as PAs. Such EHRs would benefit from modifications that encourage and facilitate PA-specific functionality, transparency, and regulatory compliance. We propose three principles to guide these modifications:

1) EHR systems must be able to identify, track, and quantify work performed by PAs and other providers.[1]
    a. Requires accurate attribution of patients, orders, test results and care provided, even when a service is performed in conjunction with, and billed under, a collaborating physician.
    b. Attribution of notes in a medical record should not be changed from the original author (the PA) if a different health professional subsequently treats the patient or modifies/makes addendum to the note.

2) EHR vendors must include PAs as part of the healthcare team that provides input into the design, build, testing, implementation, and ongoing management of EHR systems, in order to identify key aspects of PA operability which might be overlooked.

3) EHR systems must be flexible to take into account the unique situation of each PA.

[1] http://journals.lww.com/jaapa/Fulltext/2017/06000/How_electronic_health_records_can_unmask_the.17.aspx

a. Clients must be able to modify level of access granted, as well as EHR requirements, for all health professionals who use the EHR, including PAs, in order to account for a PA's specialty, scope of practice, and privileges.
b. A client's desired prerequisite in one location of an EHR (such as a co-signature) should not automatically make this a requirement elsewhere.

When designed and implemented in a manner that properly accounts for PAs, EHRs can encourage transparency, improve quality, increase patient safety, enhance operational efficiencies, provide cost savings, and enrich patient satisfaction

APPENDIX AA4
EHR POINTS FOR DISCUSSION WITH EMPLOYERS

EHR Talking Points for PA Discussion with Employers

EHR Design and Implementation

- EHRs should be designed with considerations for utilization, functionality and efficiency by PAs and other health professionals. When appropriately designed and implemented for use by all relevant health professionals, EHRs can improve quality, increase patient safety, enhance operational efficiencies, provide cost savings, and increase patient satisfaction.

- PAs should be included as part of the team that provides input into the design, build, testing, implementation, and ongoing management of EHR systems. Without PA participation, key aspects of PA participation might be overlooked. These oversights are more difficult to correct once the system is fully designed and implemented as opposed to during the design phase.

- EHRs need to be adaptable to the specialty, scope of practice, and privileges of individual PAs. The type of EHR access granted, as well as any automatic ordering restrictions, should be able to be altered based on a PA's specialty.

Transparency

- The professional work of PAs should be transparent and able to be identified through data captured by EHRs. This data should include patient encounters, as well as measure contribution to care delivery for non-reimbursed services (e.g. computerized order entry, patient care documentation, diagnostic review and follow-up, and patient communications). Care provided by PAs during "incident to" or shared visit billing, and billing under a collaborating physician should be identified as work performed by the PA.

Quality & Safety

- Improving healthcare quality and ensuring patient safety are potential benefits of EHRs. To do this, there needs to be accurate attribution of patients to PAs. EHRs need to ensure that orders and test results are appropriately attributed to the ordering PA. PAs also need to be able to accurately assess their panel of patients for population health management, compliance with quality measures, and self-assessment.

Compliance

- EHRs should reflect the regulatory requirements of federal, state and facility policy to ensure the maximum utilization of PAs.

- EHRs should ensure that the recognition of a PA's participation in patient care is not removed from the EHR when subsequent care is provided by another health professional or if an addendum is added to the medical record by another health professional.

APPENDIX AB
MEASURING PA PRODUCTIVITY

Measuring Productivity

Calculating Your Contribution

"MY PRACTICE TELLS ME that I consistently have negative numbers." Time and time again, PAs run into this problem. Measuring PA productivity is a constant struggle, especially when payers don't enroll PAs—see January's *PA Professional* for more on that—and claims go out and are paid under the physician's provider number. Incident to and shared visits, billed to Medicare under the physician's National Provider Identifier, add to the difficulties. Since claims data seem to be the only method for practices to track productivity, PAs can appear to be a cost burden rather than an asset.

PAs working in surgical practices are at further disadvantage, as they perform office and hospital visits in the global period. Global work is work that must be done and would otherwise have to be handled by a physician if the practice did not employ PAs. Unfortunately, global visits have no monetary value. By performing the global work, the PA enables a physician to schedule revenue-generating encounters, such as new patients, consultations and procedures, in time slots that would have been otherwise closed out by the non-revenue-generating global visits. Conceptually, it is obvious that the PA contributes to the financial success of the practice. From a pure accounting, claims-based/accounts-receivable standpoint; however, it appears that the PA constantly has "negative" numbers.

Measuring Productivity Explained

Tracking Relative Value Units: An RVU is a nonmonetary standard unit of measure assigned to most CPT© codes, which indicates the value of services performed by physicians, non-physician providers and other health care professionals. The total RVU for a given procedure or encounter consists of three components:

1. Work RVUs
2. Practice expense RVUs
3. Malpractice RVUs.

These values are found in the Physician Fee Schedule on the CMS Web site, *www.cms.hhs.gov*.

To "quantify" the PA's contribution to the practice, the work RVUs can be tracked for all encounters performed by the PA by using the CPT© code billed. Many billing software programs have the RVUs already loaded.

Tracking 99024: Global visits are designated by CPT code 99024 and typically are not included in the billing system because they do not generate a bill. By putting 99024 into the billing system, the office can track the volume of those visits for each provider.

If, for example, at the end of the fiscal year, the PA has handled 500 global visits and the physician has handled 20, you might be able to extrapolate that the PA enabled the physician to cover 480 revenue-generating encounters. Another way to look at it is to take those 480 encounters, split the revenue for the encounters in half and attribute 50 percent to the PA, subtracting 50 percent from the physician's revenue line. Remember, if the PA had not seen those patients, the physician would not have had open slots for the new patients/new problems/consultations. The PA's work contributed to the physician's revenue numbers.

Global Work Formula: Medicare has assigned percentages to the pre-op, intra-op and post-op work associated with global packages. This formula can be applied to surgical fees to assess the PA's contribution to the practice.

Medicare fee breakdown:
11 percent for pre-op work
76 percent for intra-op work
13 percent for post-op care

Thus, 24 percent of the global pay ment is for non-OR services.

Confused? Let's look at the example of a total knee (27447), payable at $1,769, with the final figure affected by the geographic index).

Here's a breakdown of the payment when the above formula is applied, with the final figures affected by geographic index:

Pre: $194.59
Intra: $1,344.44
Post: $229.97

If a PA does the pre-op exam and post-op global rounding/office visits, $424.56 could be "credited" or "allocated" to the PA. A separate payment of $240.58 could be officially credited to the PA for the first assist (13.6 percent of a surgeon's fee).

A true measure of PA "value" might be a first-assist payment of $240.58, plus a share of the global payment of $424.56. That's a total of $665.14.

If you are using claims data only, it is still difficult to get at the office E/M performed by the PA when it is billed under the physician's name. Tracking encounters, CPT codes, and RVUs by provider can help mitigate that hole in the data.

Applying these concepts can help physician-PA teams assess the PA's contribution to the practice. PA

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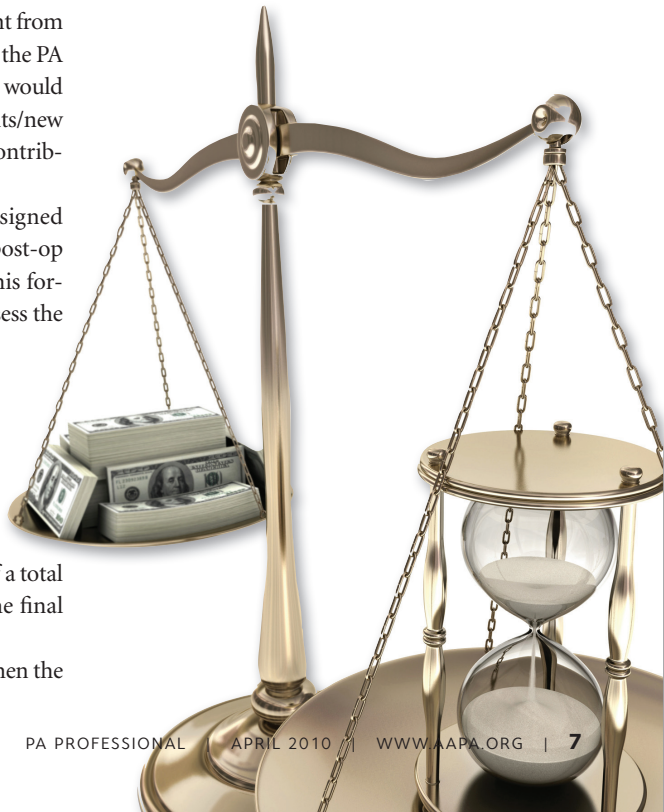

SHUTTERSTOCK

PA Productivity

Pitfalls and Pearls

ARE YOU CONSIDERING a production-based compensation package? Do you have full access to your production data? Unless you can thoroughly ascertain that all of your work is attributed to you, is appropriately valued and is incorporated into the data used to calculate your productivity, you may sell yourself short. Proceed with caution.

Physician work is often evaluated by tracking Work Relative Value Units, or wRVUs. Each CPT code is assigned a wRVU. A fair and equitable method of tracking work, wRVU-based formulas are calculated by information drawn from claims data. The wRVU is a standard that applies to all providers, no matter who performs the service or how it is reimbursed.

Claims for the physician's work are always submitted under the physician's NPI. Because the billing rules for PAs are different from those for physicians, PAs must NOT rely solely on claims data. Extra steps must be taken to ensure that PAs are recognized for their contributions to the overall production of the physician-PA team. This requires a basic understanding of PA billing and reimbursement rules:

- Many commercial payers, self-insured companies, workers' compensation plans and state Medicaid programs (25 states) do not enroll PAs. As a result, claims for services provided by the PA must be submitted under the physician's NPI number, rendering PAs "invisible" on the claim. (See URL in box below.)
- Charges submitted under the physician's NPI (although the encounter was provided by the PA) are remitted to the physician. This creates the appearance that the PA has a fairly empty accounts-receivable "bucket," while the physician's "bucket" is quite full. An accountant will understandably protest when the accounts receivable attributed to the PA barely cover the cost of the PA's salary and benefits.
- Medicare provisions such as "incident-to" and "shared visits" result in claims being submitted under the physician's NPI, making the PA invisible. Pre-op H+Ps (performed by the surgical team) and post-op visits are included in the global surgical package. PAs provide the preponderance of these visits in surgical practices, but no claim is submitted. They carry no dollar or wRVU value. The PA's contribution is invisible. Strategies and concepts to consider:
- The "1500 form," used to submit a claim for professional services, has a "rendering provider" field, Box 24 J. Although this information is not used or required by many payers, the field already exists in the practice management software and can track services provided by the PA.
- For surgical practices, the post-op global visit code 99024, must be tracked. If the PA did not perform these non-revenue-generating encounters, the physician would have to provide them. By tallying the number of 99024 encounters the PA performed, one can extrapolate the number of revenue-generating encounters that were opened up for the physician(s), enhancing productivity.
- Assign wRVUs to the pre-op H+P and post-op encounters. Attribute those wRVUs to the PA, even though the visit did not generate a claim. (For example, a typical post-op visit can be compared with the work performed for an established patient visit, 99213, wRVU= 0.97.)

For information on billing/enrollment policy for payers in your state, see the AAPA payer profiles:

Medicaid
http://bit.ly/jtYLA5

Private/commercial payers
http://bit.ly/9coIR0

Workers' Compensation
http://bit.ly/jtdHSx

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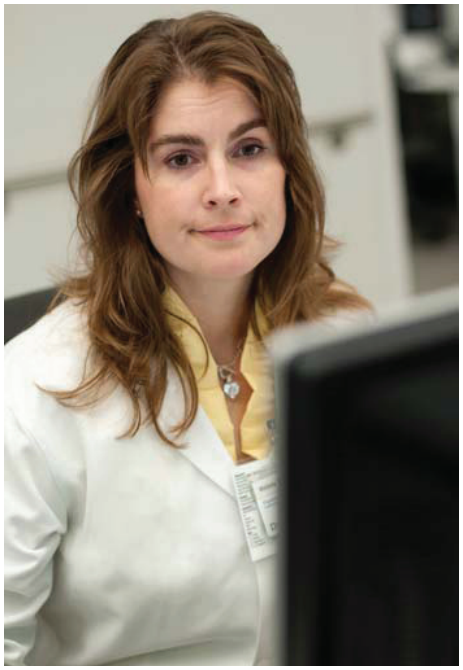

- If a PA works with one physician at all times, weigh the idea of evaluating the physician-PA team's production together, rather than as individuals.

In addition to the challenges PAs face regarding their true production value, there are many factors that are not within the PA's control. What if a new physician joins the practice, diverting the new patient and commercial payer visits, leaving the lower valued visits to the PA? What if your surgeon does not or cannot operate for a few months, eliminating your first-assist reimbursements? Are you relying on that production compensation to pay your mortgage? Stuff happens. Consider negotiating a fair base salary for peace of mind. View any production-based compensation as a bonus and an incentive to work harder, see that extra patient, or stay longer at the end of the day. Proceed with caution. **PA**

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GLOSSARY

A

Accountable Care Organizations (ACOs)

ACOs, which were created by the Affordable Care Act, are networks of healthcare professionals who collaborate to provide high-quality care efficiently and cost-effectively. ACOs allow healthcare providers to share in the savings achieved by the insurance program/company. At present, there are more than 900 government-sponsored and commercial ACOs in operation, from which more than 30 million Americans are receiving their care. Medicare ACOs that are part of the Medicare Shared Savings Program are required to have a minimum of 5,000 Medicare beneficiaries. A provision in the 2015 Medicare Physician Fee Schedule allows patients who are treated only by a PA to count toward the 5,000 beneficiary threshold.

Administrative Services Only (ASO)

The providing of the following services to a self-insured plan: actuarial, benefit plan design, claim processing, data recovery and analysis, employee benefits communication, financial advice, medical care conversions, preparation of data for reports to governmental units, stop-loss coverage, and so on. An insurer or its subsidiary typically provides these services on a contract basis.

Advanced Care Planning

A service that includes a discussion about the care a person would want to receive if they became unable to make decisions, an explanation of advance directives, and completion of advanced-directive forms. Billing for advanced care planning is based on the first 30 minutes of face-to-face encounter with the patient (or family/surrogate decision maker) and each additional 30 minutes, and can be billed in addition to other E/M services.

Advancing Care Information (ACI)

A category in the Merit-based Incentive Payment System (MIPS) that determines a performance-based payment adjustment. ACI is based on key measures of interoperability and information exchange, and comprises 25% of the MIPS score for the performance year 2018.

Adverse Selection

The enrollment of a disproportionate percentage of persons who tend to be of greater risk because they are more ill and file more medical claims than the average person.

Affordable Care Act (ACA)

The health reform law passed by Congress and signed by President Barack Obama in March 2010 that introduced significant changes to the U.S. health system. The law had numerous provisions aimed at increasing access to care, expanding coverage, increasing quality, and lowering costs. Many intended and unintended effects of the law remain controversial. In June 2012, the Supreme Court upheld the individual mandate, a central provision of the law (repealed by Congress in 2017); however, the Supreme

Court also made the previously required expansion of Medicaid at the discretion of each state. As of March 2016, it was estimated that 20 million people have gained coverage under the ACA, and the Congressional Budget Office estimates it will reduce the deficit. The law continues to be a topic of political discussion and divided public opinion.

Alternative Dispute Resolution (ADR)

A range of dispute-settling mechanisms that attempt to resolve medical liability (malpractice) claims in a more efficient, timely, and less expensive manner. The central theme is to settle disputes outside of the court system. ADR methods might include pretrial screening panels and "private courts" staffed by retired judges.

Alternative Payment Models (APMs)

New models of reimbursement (beyond traditional fee-for-service) being explored. The goal of these models is primarily efficiency through reducing healthcare costs while incentivizing quality. Many APMs are currently being implemented and tested by the Center for Medicare and Medicaid Innovation, created by the ACA. Three examples of alternative payment models are accountable care organizations (ACOs), advanced patient-centered medical homes, and bundled payments. ACOs, which were created by the ACA, are groups of health providers who deliver coordinated care with reimbursement linked directly to performance metrics on quality and cost. Medical homes are team-oriented delivery systems intended to provide comprehensive care to patients through proper communication and coordination. Bundled payments are a method of reimbursement based on the episode of care and its expected cost. Through the Quality Payment Program (QPP), Advanced APMs allow practices to potentially earn more for taking on some risk related to their patients' outcomes

Ambulatory Surgical Center (ASC)

A facility (either hospital-sponsored or independently sponsored, but often located in close proximity to a hospital) that performs surgical procedures that in the past had been done on an inpatient basis. ASCs strive to provide patient convenience while saving costs.

American Academy of PAs (AAPA)

The professional association for PAs of all specialties. It promotes quality, cost-effective, accessible healthcare and the professional and personal development of PAs.

Any-Willing-Provider (AWP) Provisions

Laws or mandates that require insurers (or managed care organizations) to permit any state-authorized healthcare provider to participate in their network as long as the provider is willing to abide by the terms and conditions of the insurer's contract. As of July 1997, 27 states had enacted some type of any-willing-provider legislation.

Assignment

A practice accepts, as payment in full, the Medicare-approved amount for providing a service to a Medicare beneficiary — even if the Medicare payment is lower than the amount the practice normally charges for that particular service. If a practice accepts assignment, then it is not allowed to bill Medicare beneficiaries for the difference between Medicare's approved amount and the practice's normal charges for a service, called "balance billing." Medicare requires that PAs accept assignment. For example, if a

practice normally charges $65 to provide a particular service and Medicare's approved amount is $50, then under assignment, the Medicare patient cannot be charged the $15 difference.

Do not confuse balance billing with the coinsurance amount. In the above example of the $50 approved amount, the Medicare beneficiary coinsurance would be 20%of the approved amount or $10 (assuming that the deductible had already been met). By law, the practice is required to bill the patient for this 20% coinsurance amount.

Average Adjusted Per Capita Cost (AAPC)

Capitation arrangement between a managed care organization (MCO) and Medicare in which the MCO agrees to accept a fee for Medicare patients enrolled in its plan; this fee is an estimate of what Medicare would have spent to provide care if the enrollee was in Medicare's fee-for-service program.

B

Balance Billing

The practice of a provider billing a patient for charges not paid for by an insurer. See "Assignment."

Benchmarking

Within a system of total quality management, benchmarking is the process of comparing an organization's or practitioner's performance and efficiency with that of similar organizations or practitioners.

C

Capitation

A method of paying for healthcare services whereby a practitioner or hospital is paid a fixed amount per patient to provide covered medical care for a specified period. Typically paid on a per month basis, the amount of payment does not change even if the actual cost of treating the patient exceeds the predetermined, fixed amount.

Care Plan Oversight (CPO)

Care plan oversight involves coordination of care, review of lab tests and studies, and assessments of care decisions with other healthcare professionals and family members in a home health setting. CPT codes 99374-99380 are time-based codes that reflect the time a healthcare professional devotes to providing these services.

Carve-outs

The process of attempting to manage risk by removing (or "carving out") services over which a provider or provider group has no control. For example, a provider may want to carve out X-ray and laboratory services because those services are delivered to patients at another location by an unrelated medical entity. Since the provider has no control over the management or cost of those X-ray or lab services, he or she would not want to be responsible for keeping costs in line under a capitated payment system.

Case Management

The process by which all health-related aspects of a patient's care are managed by a designated healthcare professional. Case managers provide coordination for designated components of healthcare, such as appropriate referral to consultants, specialists, hospitals, ancillary providers, and services. Case management is intended to ensure continuity of services and proper accessibility in order to overcome fragmented healthcare systems or the improper use of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs.

Catastrophic Health Insurance

Health insurance that goes beyond the typical basic and major medical benefits and covers severe, costly, and prolonged illness, the cost of which could threaten financial ruin for families and individuals.

Catchment Area

The geographic area from which a health maintenance organization (HMO) or other managed care organization draws its patients.

Center for Medicare and Medicaid Innovation (CMMI)

Sometimes known as "The Innovation Center," CMMI is a department newly created under the ACA that seeks to develop and test alternative payment and delivery models with the intention of increasing quality of care while reducing costs. CMMI then analyzes these models for best practices. To date, CMMI has implemented or is currently testing over 80 different models.

Centers for Medicare and Medicaid Services (CMS)

The federal agency within the Department of Health and Human Services responsible for administering the Medicare program and the federal components of the Medicaid program.

Certificate of Authority (COA)

A certificate, issued by a state government, that licenses the operation of an HMO.

Certificate of Medical Necessity (CMN)

A written order authorizing Medicare coverage for durable medical equipment. Pursuant to Medicare Transmittal 4, dated January 31, 2001, PAs may sign certificates of medical necessity and orders if following state law guidelines for supervision and scope of practice.

Certificate of Need (CON)

First used in the late 1960s and 1970s, the CON was directed at hospitals, nursing homes, ambulatory care facilities, and mobile technology units (e.g., MRI machines). CON laws/regulations required state approval for major capital expenditures, purchases of high technology equipment, and the expansion of services. The idea behind the CON concept was that since healthcare facilities tend to be supported by public funds, those projects should meet a demonstrated public need. In the 1980s, a number of states eliminated their CON programs. Some of those states are now reviving their CON laws.

Certified Electronic Health Record

An EHR that has met established criteria and standards for structured data, as determined by CMS and the Office of the National Coordinator for Health Information Technology, to qualify for use in the Medicare and Medicaid EHR Incentive Programs

Children's Health Insurance Program (CHIP)

CHIP provides health coverage to eligible children in families with incomes too high to qualify for Medicaid but who can't afford private coverage. The program is funded jointly by states and the federal government with federal matching funds.

Chronic Care Management

Non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. Chronic care management services that require at least 20 minutes of clinical staff time per calendar month can be billed if the following requirements are met: care is established and directed by a physician or other qualified healthcare professional (including a PA); a patient has two or more chronic conditions expected to last at least 12 months; and the chronic conditions cause a risk of acute exacerbation/decompensation, functional decline, or death. Only one practitioner may be paid for chronic care management services per patient per calendar month.

Clinical Practice Guideline

Systematically developed statement or algorithm that helps healthcare providers optimize the care of a patient with a specific condition. These guidelines improve patient care by providing a systematic review of evidence and an assessment of the benefits and harm of alternative management and treatment options. reduce duplication of procedures and facilitate risk management.

CMS 1500 Form

The standard Medicare claim form used by providers and suppliers. In addition, many commercial insurers are using the 1500 form in an attempt to bring consistency to the medical claims process.

Credentialing

The process of reviewing a healthcare professional's qualifications (i.e., education, training, experience, licensure/certification) for the purpose of determining whether they meet the criteria for clinical privileging.

Co-insurance

An amount of money that the insured pays directly to a provider (practitioner or facility) for medical services. This amount is typically a percent of the cost of the overall service, as opposed to a copayment, which is typically a fixed amount.

Collaboration

The process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients, with each collaborator performing actions he or she is licensed or otherwise authorized to perform. Collaboration shall be continuous but shall not be construed to require the physical presence of

the physician at the time and place that services are rendered.

Commercial Payers

Also known as private payers, they are payers of healthcare services other than the patient or the government. Commercial payers have various methods of payment (e.g. capitation, fee-for-service, fee-for-performance) and may or may not follow CMS billing and reimbursement guidelines.

Common-law Test

Internal Revenue Service guidelines used to help determine if a valid work relation exists without a W-2 employment relationship. Also known as the common-law control test.

Community Rating

A system of charging all people the same average rate for health insurance within a given area, regardless of their age, claims history, or medical condition. Risk is spread evenly across the entire community. The ACA implements a form of community rating for individual and small group plans, prohibiting deviations in price based on health status, medical history and genetic information, and allowing variability only as a result of age (limited), geography, family size, and tobacco use (limited).

Competitive Medical Plan (CMP)

A type of managed care organization created by the Tax Equity and Fiscal Responsibility Act of 1982 to facilitate the enrollment of Medicare beneficiaries into managed care plans. CMPs are organized and financed much like HMOs but are not bound by many of the typical HMO federal regulatory requirements.

Concurrent Review

Ongoing review of inpatient status during a patient's hospital stay to confirm the need for continued care; one process used in utilization management.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Surveys used to evaluate patients' experience with healthcare, compare healthcare providers, and improve quality of healthcare services. CAHPS surveys are overseen by the Agency for Healthcare Research and Quality and must be administered by a qualified vendor. The surveys are used by CMS as part of its value-based payment incentive.

Consumer-directed Healthcare

A movement to control healthcare costs by involving patients in financial responsibility and healthcare decision making. Consumer-directed healthcare plans tend to have high deductibles combined with health reimbursement or savings accounts. The high deductibles make the premiums inexpensive and also help the insured perceive the true cost of care.

Continuing Medical Education (CME)

Ongoing medical training offered to medical personnel. PAs need 100 hours of CME every two years to maintain their PA-C designation.

Continuous Quality Improvement (CQI)

Business management technique that assesses and tries to improve internal operating procedures in an ongoing fashion.

Conversion Privilege

The right to switch insurance plans on an annual basis regardless of age or physical condition. HMOs must provide an annual renewal period so that their members have the right to remain with the HMO on a voluntary basis or convert to another plan if they wish. A conversion privilege also refers to the right of an insured employee (in an employer-sponsored group plan) to convert to an individual health plan/policy if the group plan is canceled or if the individual's employment ends.

Coordination of Benefits (COB)

A typical insurance plan provision whereby responsibility for payment for medical services is shared among insurers when a person is covered by more than one health plan or policy. This coordination attempts to avoid a person being reimbursed twice for the same medical service.

Copayment (Copay)

An amount of money that the insured pays directly to a provider (practitioner or facility) for medical services. This amount is typically a fixed number (as opposed to coinsurance, which is typically a percent of the cost of the overall service).

Co-signature

A second signature, generally by a physician, to verify or validate another providers order or documentation. Co-signature requirements are determined by federal policy, state law, or by individual hospital policy.

Cost-Based Reimbursement

A method of reimbursing medical services based on the costs incurred in treating the patient (as opposed to a pre-established fee for each individual medical service). Independent certified rural health clinics (RHCs) are reimbursed according to a cost-based method. That is, the actual cost of the facility (rent or mortgage), utilities, medical provider(s), and clerical staff salaries, equipment, etc., divided by the number of patients treated in the clinic within a year, yields the per-patient reimbursement amount to which the clinic is entitled. There is a ceiling on the per-patient amount that RHCs can be reimbursed under this system. The 2017 cap for RHCs is $82.30 per patient. That cap tends to increase each year based on a medical inflation formula determined by CMS.

Hospitals can also be reimbursed using the cost-based method for certain outpatient services. However, since 1983, inpatient hospital services for Medicare patients have been paid on a prospective basis with preset payment amount based on the particular procedure. See Diagnostic Related Groups.

Cost Shifting

When those who are uninsured receive and are unable to pay for medical care, the cost of that uncompensated care is shifted or passed along to those who do have insurance in the form of higher fees, hospital charges, and insurance premiums. Although hospitals and other providers may "write off" the

cost of this uncompensated care, there is little doubt that the overall cost of healthcare is substantially increased for those who do pay for health coverage. Also, most will acknowledge that the Medicare and Medicaid programs play a role in cost shifting. Some studies have indicated that Medicare's payment rates for services are approximately 40% lower than private insurance company payment rates for similar services.

Critical Access Hospital (CAH)

A CMS designation to certain rural hospitals to reduce financial vulnerability of a hospital and improve access to healthcare. Conditions of participation as a CAH include being located in a rural area, being of limited size (no more than 25 inpatient beds), maintaining a short (no more than 96 hours) average length of stay, and offering 24-hour, 7-day-a-week emergency care. The requirements are designed to encourage CAHs to focus on providing care for common conditions, providing outpatient care, and referring to larger hospitals for less common or more complex conditions. In exchange, CAHs receive cost-based reimbursement.

Current Procedure Terminology (CPT) Codes

CPT codes represent a system developed by the American Medical Association (AMA) to describe medical procedures performed by physicians. The five-digit CPT codes, which are also used by PAs since they provide the same medical services physicians deliver, are updated annually. Beginning in 1993, the AMA and CMS embarked on a formal effort to open up the CPT coding system to certain other nonphysician [*sic*] practitioners, such as physical and occupational therapists, speech language professionals, and dieticians, whose services in the past had not been adequately described by the CPT system.

D

Deductible

An amount of money the insured person is required to pay for medical care before any money is paid by the third-party payer. For example, Medicare beneficiaries must satisfy an annual deductible of $1,470 for Part B services before Medicare will begin to pay 80% of the medical charges incurred thereafter.

Diagnostic Related Groups (DRGs)

A Medicare payment system in which the fees paid for inpatient hospital procedures are pre-established. Generally, Medicare claims for those procedures are paid at that preset amount, regardless of the actual cost to the hospital. There are special cost adjustments for unique medical circumstances or cases.

Discharge Management

Discharge management services include the face-to-face E/M service, completion of discharge records including the discharge summary, prescriptions, arranging for follow-ups, and other patient management. Inpatient hospital discharge management, and subsequent reimbursement, is based on whether more or fewer than 30 minutes were required for discharge management services (CPT code 99238 for 30 minutes or fewer or 99239 for more than 30 minutes). Observation discharge management services are not billed based on time. Instead, when a patient is held for observation and discharged on a different calendar date, the CPT code 99217 is used for the observation discharge service. No discharge CPT should be reported if the patient is discharged on the same calendar date.

Discharge Planning

An assessment process that determines the appropriate time for patients to be released from a hospital or facility, the likelihood of a patient needing post-discharge services, and a patient's capacity for self-care. Discharge planning is required by CMS for all patients likely to suffer adverse health consequences upon discharge and for patients upon the patient's, surrogate's, or healthcare provider's request. CMS requires that a registered nurse, social worker, or other qualified person develop or supervise the evaluation and discharge planning.

Discharge Summary

A component of discharge management services, it is a summary of a patient's medical condition and treatment. A discharge summary should include a summary of the patient's stay, including symptoms, treatments, outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. A PA may furnish the documentation of the discharge summary.

Discounted Fee-for-Service

Similar to fee-for-service, but when the practitioner submits a claim, the MCO subtracts a certain percentage (specified in a contract) and pays the discounted amount.

Donut Hole

A name given to the gap in Medicare Part D prescription drug coverage after a beneficiary reaches the coverage limit and before reaching catastrophic coverage. In the past, Medicare did not assist in covering drug costs in this range and beneficiaries were responsible for the full cost of each medication. However, the ACA implemented policy to close the gap by 2020 and provide rebates (financial assistance) for those who find themselves in this range before then.

Dual Choice

The opportunity for an insured person within a group health plan to choose from two or more different arrangements for healthcare coverage (e.g., between an indemnity/fee-for-service plan and an HMO). Section 1310 of the federal HMO Act requires that HMOs offer the dual choice option.

Dual Eligible

A health insurance status of those who are eligible for, or are already covered by, both the Medicare and Medicaid programs. These individuals tend to be the sickest and poorest of the population in each program and comprise a significant amount of programmatic spending as well. The ACA created an office designed specifically for promoting proper coordination between these programs that aims to help this population. There are approximately 9 million dual eligible beneficiaries.

Durable Medical Equipment (DME)

Durable medical equipment includes any type of medically necessary device or appliance (such as a wheelchair, orthotic shoes, or breathing apparatus) that enables the beneficiary to better perform activities of daily living. Medicare will reimburse for this equipment when it is ordered by a medical professional.

E

Economic Credentialing

Determining a practitioner's ability to participate in a practice or network based on the practitioner's pattern of resource use and its financial impact on the network/practice.

Elective Procedure

Usually refers to medical procedures, particularly surgeries, which are not immediately necessary to maintain life or health (i.e., procedures that can often be scheduled weeks or months in advance).

Electronic Health Records (EHRs)

A digitalized version of a patient's chart that contains health information, diagnostic results, and documentation of health encounters. EHRs allow healthcare providers to track data over time, identify patients who are due for preventive visits and screening, monitor how patients measure up to certain parameters, such as vaccinations and blood pressure reading, and improve overall quality of care in a practice. The intention for these records is to provide a simple method for information transfer, reduce medical mistakes, streamline processes, and reduce healthcare inefficiency and waste. Incentive programs have been developed to encourage the use of EHRs.

Eligibility

An individual's status with respect to receiving medical services as a covered benefit.

Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act (ERISA) of 1974, Public Law 93-406, sets federal requirements for private pension plans. ERISA also affects businesses that self-insure their employee health plans by exempting them from individual state insurance laws, regulations, and mandates.

Essential Community Provider

A term that describes practitioners who are essential to the delivery of primary care and preventive services, especially in rural and urban underserved communities.

Essential Health Benefits (EHBs)

Benefits required for inclusion in health plans to meet minimum qualifications. There are a set of 10 categories required to be covered in insurance plans in the individual and small group market, whether inside Health Insurance Marketplaces or not. EHBs will vary by state depending on that particular state's chosen "benchmark plan" that other plans have to provide coverage similar to, with deviation allowed in specific services as long as overall actuarial value of each category is maintained. The 10 EHB categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).

Evaluation and Management Services (E/M Services)

Often described as cognitive services, these are patient examination functions performed during office or hospital visits. E/M services consist largely of taking the patient's history, physical examination and medical decision making. Under Medicare's Resource-based Relative Value Scale (which went into effect January 1, 1992), CMS has attempted to upgrade the value (and fee schedules) for E/M services while holding down the fees paid for surgical and more technical types of services.

Exclusive Provider Organization (EPO)

EPOs are similar to preferred provider organizations (PPOs) in their organization and purpose. Unlike PPOs, however, EPOs completely limit their members to EPO participating providers for all healthcare services. The EPO does not cover services received from other "non-EPO" providers (except, perhaps, for emergency situations). Some EPOs parallel HMOs in that they use a "gatekeeper" approach to authorize access to non-primary care services.

Experience Rating

A method insurance companies use in determining risk and setting premiums (or rates) based on the dollar amount and/or frequency of a group's past medical claims. Groups whose workers have a higher incidence of illness and claims tend to be charged the highest premiums. Some suggest that this causes employers to discriminate against and not hire workers who have pre-existing medical problems. However, as a result of the ACA, insurance companies are no longer able to deny coverage or charge more as a result of a pre-existing condition. Experience rating is the opposite of community rating and is also not permitted under federal HMO qualification requirements.

Explanation of Benefits (EOB)

An explanation, prepared by a third-party payer or administrator, of the covered and noncovered medical benefits or the denial of such benefits.

F

Federal Employees Health Benefits Program (FEHBP)

The Federal Employees Health Benefits Program, administered through the U.S. Office of Personnel Management, is the largest employer-sponsored health plan in the world, covering federal employees, retirees, and their dependents, numbering approximately 8 million in 2010.

Federal Poverty Level (FPL)

Determined by the Department of Health and Human Services annually, this measure of income level is used to benchmark eligibility for many federal programs, including Medicaid, CHIP, Head Start, SNAP, financial assistance in Health Insurance Marketplaces, and more. The actual dollar amount varies depending on family size and is the same for all contiguous states, but higher for Alaska and Hawaii.

Federally Qualified HMOs

A health insurance/provider organization that offers a wide range of comprehensive healthcare services to a specific group for a fixed payment (premium). Federally Qualified Health Maintenance Organizations are HMOs that are eligible for qualification under federal law (Public Law 93-222). Enacted in 1973 and

known as the HMO Act, it authorized the expenditure of federal funds to establish and develop HMOs over a five-year period. To become federally qualified, HMOs must provide a specific range of basic health services and offer the subscriber the opportunity to purchase optional health services. HMOs that meet certain federally stipulated provisions aimed at protecting consumers (for example, providing a broad range of basic health services, assuring financial solvency and monitoring quality of care) are eligible to apply for federal qualification. The qualification process is administered by CMS.

Fee-for-Service (FFS)

A system of payment for healthcare services whereby a fee is rendered for each service delivered (sometimes known as indemnity insurance). Under a FFS system, costs increase not only if the fee for the service increases, but also if more services (e.g. visits and procedures) are provided. One of the concerns of FFS is that providers have an economic incentive to perform more services to increase payments. This traditional method contrasts with payment by episode of illness, payment per patient (capitation), or by fee-for-value.

Fee-for-Value (FFV)

A value-based system of reimbursement that encourages healthcare providers to deliver the best care at the lowest cost. In contrast with fee-for-service, value-based reimbursement shifts payment from quantity of care to quality of care. Examples include: APMs, MIPS, the Hospital-Acquired Condition (HAC) Reduction Program, the Hospital Readmission Reduction (HRR) Program, and other value-based programs.

First Assisting at Surgery

First assisting at surgery involves a qualified healthcare professional providing primary assistance to a surgeon to facilitate a surgery and may involve opening and closure of incisions, assisting in visualization of the operating field, harvesting surgical grafts, providing hemostasis, and other intraoperative duties. PAs are authorized to personally perform minor surgical procedures and can provide the same range of first assist duties as physicians on major surgical cases; however, PAs cannot act as primary surgeons on major surgical cases. Medicare reimburses PAs at 85% of the physician first-assisting rate or 13.6% of the primary surgeon's fee. Reimbursements paid by other payers vary. PAs should be aware of the Medicare list of approximately 1,900 CPT codes for which a first assistant at surgery (either a PA, physician, or other qualified healthcare professional) will not be reimbursed.

First Dollar Coverage

A fee-for-service policy that has no deductibles and covers services from the first dollar of an individual's medical expenses.

Flexible Spending Account (FSA)

A tax-exempt account for qualified medical expenses (as defined by §213(d) of the IRS code) of the account holder and his or her spouse and/or dependents. Employees cannot take the funds in an FSA with them if they change employers. FSAs have optional rollovers determined by the employer. A grace period gives employees an additional 2.5 months to use the previous year's funds, at the end of which time all unused funds are forfeited. A carryover allows employees to roll over up to $500 of unused funds into the next year.

Formulary

A list of approved prescription drugs determined by a managed care plan for use by its subscribers. Some formularies include only generic equivalents of name-brand pharmaceuticals.

G

Gatekeeping

The process by which a primary care provider (or other trained individual) is the first point of contact for a patient seeking care. The gatekeeper evaluates the patient's medical needs and coordinates all diagnostic testing and referrals required for appropriate medical care. To receive referrals to specialists and hospitals, the care must be preauthorized by the gatekeeper unless there is an emergency. Gatekeeping is closely related to the functions of a case manager.

Global Budgeting

A term referring to either a state or national limit on total healthcare expenditures. Global budgeting is a cost-control strategy to get hospitals, medical providers, and drug companies to operate more efficiently within certain cost parameters. Most global budgeting proposals would apportion a certain amount of money to each state (based on population and health conditions) and leave to the states the task of allocating reimbursement among the various healthcare providers and institutions.

Global Surgical Fees

A type of bundled fee paid for all necessary services normally furnished related to a surgery before, during, and after a procedure. The number of postoperative days included in the bundled fee is determined by the procedure. Endoscopies and some minor procedures have no postoperative period, other minor procedures have a 10-day postoperative period, and major procedures have a 90-day postoperative period. Medical encounters unrelated to the diagnosis for which the surgical procedure was performed, unless due to a complication caused by surgery, are not included in the global surgical fees.

Grandfathered Health Plan

As used by the ACA, a grandfathered health plan is either a group plan that was created, or an individual plan that was purchased, before passage of the law, and is exempt from many of the new requirements of the ACA that benefit consumers. These grandfathered plans lose this status if they make certain benefit or price changes. They would then need to comply with all ACA requirements. Grandfathered plans must notify consumers of their status as such.

Group Model HMO

A system in which providers are members of a partnership or service corporation that contracts with an HMO to provide medical care to the HMO subscribers for a fixed (capitated) monthly fee. Often, providers share equipment, records, and personnel (as in the staff model), but are not employees of the HMO.

Group Practice Without Walls (GPWW)

A type of integrated health system that consists of a network of independent healthcare professionals who practice in their own offices, but function as a group practice; benefits include leverage with MCO

contracting, coordinated purchases and greater autonomy. See Virtual Groups.

Guaranteed Issue

A term representing a provision of the ACA that prohibits health plans in the individual and small group health markets from denying consumers access to insurance coverage based on pre-existing health conditions.

H

Health Alliances

In some healthcare reform proposals, a state or regional entity that would coalesce consumers' purchasing power to negotiate prices with competing private health plans.

Healthcare Common Procedure Coding system (HCPCs)

CMS's Healthcare Common Procedure Coding System (HCPCS) contains the CMS codes to be used when billing Medicare for services and supplies furnished to Medicare beneficiaries. The CPT codes contained within the HCPCS are used by Medicaid and other health insurance programs as well.

Health Insurance Marketplace (Also known as Health Insurance Exchange)

Websites through which individuals and small businesses can compare and contrast private health plan coverage options, learn whether they are eligible for Medicaid (individuals), and determine the amount of financial assistance for which they are eligible. The health insurance marketplace was created by the ACA and implemented in late 2013 in its first open enrollment period. Under the ACA, financial assistance in the form of advanced premium-adjusting tax credits and cost-sharing assistance is available to many of those who purchase plans through Health Insurance Marketplaces. Individuals can use the marketplace year-round to either sign up for Medicaid, or, in the case of a special circumstance, sign up for a private plan.

Health Maintenance Organization (HMO)

A health insurance/provider organization that offers a wide range of comprehensive healthcare services to a specific group for a fixed payment or premium. Claims are normally not submitted for reimbursement by subscribers (patients), and the premium does not vary in relation to the number or type of medical services received. Services usually include primary care, emergency care, acute hospital care, extended care, and rehabilitation.

Health Plan Employer Data Information Set (HEDIS)

A set of quality standards established by the NCQA to help purchasers of healthcare plans evaluate the performance and value of different health plans.

Health Professional Shortage Area (HPSA)

Geographic areas, population groups, and facilities with shortages of healthcare professionals. For federal rural designation, essentially three criteria must be met: the area is a rational area for the delivery of primary medical services; there is a ratio of population to primary care physicians of at least 3,500 to 1 (with certain exceptions); and primary care in the contiguous area is overtaxed, excessively distant, or

inaccessible to the population of the area under consideration.

Health Reimbursement Accounts (HRAs)

Employer-funded accounts that reimburse employees for qualified medical expenses (as defined by §213(d) of the IRS code) and health insurance premiums. HRA monies are owned by the employer and have no value to the employee if the employee leaves the employer.

Health Savings Accounts (HSAs)

A tax-exempt account for qualified medical expenses (as defined by §213(d) of the IRS code) of the account holder and his or her spouse and/or dependents. HSAs can be set up by employers, employees, or family members, and the employee continues to control the funds if he or she changes jobs. Any money left in an HSA at the end of the year can be rolled over into the next year. An employee must have a high deductible health plan (HDHP) to qualify for an HSA. The account cannot be used to pay health insurance premiums unless the account holder is receiving unemployment or COBRA benefits. Employee contributions to HSAs are tax-deductible and interest on funds in the account accrues tax-free.

High-deductible Health Plan (HDHP)

A health insurance plan with lower premiums and higher deductibles than a traditional health plan. The IRS defines a high-deductible health plan as any plan with a deductible of at least $1,300 for an individual or $2,600 for a family. HDHPs are usually paired with HSAs to pay for higher out-of-pocket costs.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed by Congress in 1996 containing provisions that allow a person to qualify immediately for comparable health insurance when that individual changes jobs/employment relationships; establish and mandate the use of national electronic standards to facilitate the efficient exchanges of healthcare data between healthcare professionals, insurance companies, and other parties; and provide guidelines to protect the security and privacy of an individual's healthcare information.

HMO/PPO Hybrid

Sometimes known as an open-ended HMO or a point-of-service plan, this model gives enrollees the option of choosing providers outside the plan each time they seek medical care. However, there are financial incentives, such as lower copayments and deductibles, to encourage subscribers to use plan-affiliated providers.

Hold Harmless Clause

A provision often found in managed care contracts in which the managed care entity and the healthcare practitioner hold each other not to be liable if the other party is found liable for malpractice or corporate malfeasance. This language does not necessarily preclude a managed care entity from being sued if one of its practitioners is sued.

Home Health Agency

An entity that specializes in providing nursing and therapeutic services in an individual's home.

Hospice
Supportive care focused on comfort and quality of life instead of on "curing" disease. Hospice care includes services provided to a terminally ill person under Part A Medicare from a hospice program (either in a residence or facility) under the written plan of the attending physician or NP, and on the recommendation on the hospice medical director. Based on advocacy work of the AAPA, as of January 1, 2019, PAs will be able to treat hospice patients under Medicare and will be authorized to act as an "attending physician" for Medicare beneficiaries who have chosen the hospice benefit.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Surveys

A survey to measure patients' perceptions of their hospital experience that allows comparisons to be made across hospitals. HCAHPS scores affect hospital payment by CMS through the Hospital Value-Based Purchasing program.

I

Improvement Activities

Broadly, a process of evaluating and improving clinical practice, care delivery, and health outcomes. Improvement activities may also more specifically refer to the name of a performance category in the Merit-based Incentive Payment System (MIPS) that determines a performance-based payment adjustment and comprises 15% of the MIPS score for the performance year 2018.

"Incident-to" Provision

A term used to describe physician-type services delivered to Medicare beneficiaries in offices or clinics by practitioners such as PAs. According to the Medicare Carriers Manual, "incident-to" services are those services "ordinarily performed by the physician himself or herself, such as minor surgery, setting cast [sic] or simple fractures, reading X-rays, and other activities that involve the evaluation or treatment of a patient's condition." See a more detailed explanation of this concept in the Medicare "incident-to" section of this guide.

Interoperability

The ability of systems to exchange and use electronic health information from other systems without special effort on the part of the user. The 21st Century Cures Act, in part, addressed electronic accessibility of health information and established six categories of standards that are required for interoperability, which include vocabulary and terminology, content and structure, transport of information, security, service, and querying and requesting health information for exchange and use. Providers who use a certified EHR with interoperability and information exchange are eligible to receive an incentive score in the Advancing Care Information component of QPP.

Independent Contractor

A person who contracts to perform services for others but who does not have the legal status of a W2 employee. Also see "Common-Law Test."

Independent Practice Association (IPA)

An organization of providers that treat a specific group of patients (such as HMO enrollees) on a prepaid, capitated payment basis, but also continue to treat their own private, traditional, fee-for-service patients.

Care for all patients usually occurs in the providers' own offices. Providers often share the risk of the total cost of care for the "IPA" patients by having some portion of the pre-negotiated fee withheld (i.e., 20% to 30%) and put into a risk pool. If the IPA has a profitable year, the risk pool of money is shared among the participating providers. Also known as individual practice associations.

Individual Mandate

A provision of the ACA that requires individuals who do not qualify for an exemption to possess sufficient health insurance or otherwise pay a penalty. This was intended to reduce uncompensated care and expand insurance plan risk pools to reduce coverage price. The penalty increased over the first three years. The legality of the individual mandate was upheld in 2012 by the U.S. Supreme Court. The individual mandate was repealed by Congress in December 2017.

Initial Visit

Generally considered the first (or initial) visit for a patient for a particular medical condition, which PAs may perform if not prohibited by state law or institutional policy. However, to qualify for Medicare's "incident-to" billing provision, a physician must perform the initial visit with a patient for a particular medical condition, diagnose the patient's condition, and establish a plan of care.

International Classification of Diseases (ICD)

Also known as ICD-10 (10th edition), the ICD represents the diagnosis coding system used by providers, hospitals, and medical facilities. The ICD-10 deals with diagnosis while the CPT® coding system concentrates on actual procedures performed.

J

Job Lock

When an individual stays in a job strictly because of the fear of losing existing health coverage and of not being able to obtain comparable health insurance coverage at the new job. Pre-existing condition limitations, waiting periods, denied coverage, and exposure to high premiums are all components of this problem.

L

Limits (Annual and Lifetime)

Prior to the ACA, insurers were able to put a dollar cap on the amount they would pay for services for a beneficiary in a year. These were known as annual limits. Insurance companies were also able to put a dollar cap on the amount they would pay for services over the entire time a beneficiary was enrolled in the plan. These were known as lifetime limits. After these limits were reached, the consumer was expected to cover all costs beyond the limits. The ACA eliminated these annual and lifetime limits on essential services.

Locum Tenens

A Latin phrase meaning to "hold the place of," locum tenens is the medical staffing practice of substituting healthcare practitioners when they are absent. CMS does not require a locum tenens physician to enroll in Medicare if locum tenens regulations are met. Instead, Medicare claims are

submitted under the regular physician that is being substituted. Under CMS, locum tenens billing only applies to physicians; a PA or NP serving as a locum tenens would need to be enrolled in Medicare and follow traditional Medicare billing rules.

Long-term Care (LTC)

Healthcare for patients with chronic disabilities or who suffer from serious cognitive impairment and require assistance with the routine activities of daily living; types include residential, intermediate, subacute, and elder care.

Low-volume Threshold

A CMS-determined volume of care benchmark that a healthcare professional or participating group must meet to be eligible to participate in MIPS. The low-volume threshold for 2018 is $90,000 in Medicare charges or fewer than 200 unique Medicare patients per year.

M

Managed Care

The practice of a health entity attempting to control costs by closely monitoring and managing patient treatment decisions, limiting referrals to outside providers, and generally requiring preauthorization for hospital care and surgical procedures. Health maintenance organizations and preferred provider organizations are often considered to be prototype managed care providers. However, a traditional fee-for-service plan could be considered a managed care entity if it has set procedures for utilization review or requirements, such as hospital precertification. Managed care organizations (MCOs) and insurers have become less restrictive in their policies, giving subscribers more control of their treatment decisions.

Managed Care Organization (MCO)

A generic term that includes all forms of organizations that provide managed healthcare services (e.g., HMOs, PPOs, CMPs, EPOs, preferred provider arrangements [PPAs]).

Management Service Organization (MSO)

An organization that provides administrative, management, financial, and managed care contracting services to providers, particularly physician group practices. MSOs are used by hospitals to help their affiliated physicians.

Medicaid

A jointly funded federal/state program that provides medical care for certain low-income individuals, families with dependent children, the aged, and the disabled. These categories have been dropped in some states, leaving eligibility to rely on income level alone (see Medicaid Expansion). The Medicaid program started on January 1, 1966. By September 2016, the program, including the Children's Health Insurance Program, covered approximately 73 million people, having increased by millions in recent years due to Medicaid expansion.

Meaningful Use

A term used in CMS' Electronic Health Record (EHR) Incentive Program to indicate successful

application of certified EHR technology to improve quality, safety, and efficiency, reduce health disparities, engage patients and family, improve care coordination and maintain privacy and security of patient health information. Certain meaningful use objectives must be met by eligible professionals to qualify for Medicare and Medicaid EHR incentive. Meaningful use is replaced by the Advancing Care Information category of Medicare's Merit-based Incentive Payment System (MIPS) in 2017, except for in hospitals and professionals receiving EHR incentive payments.

Medicaid Expansion

A provision of the ACA that required the expansion of Medicaid eligibility to all individuals with incomes up to 138% of the federal poverty level. However, as a result of the 2012 Supreme Court decision, it was deemed excessively coercive to require all states to expand, and Medicaid expansion became optional. Before expansion, states varied significantly in the ranges they covered and most did not cover childless adults. In states that expanded Medicaid coverage, the federal government paid 100% of the cost at first, and has been slowly reducing it to 90%, where it will remain from 2020 onward. Thirty-two states and the District of Columbia expanded Medicaid as a result of the ACA.

Medicaid Waiver

An exemption to existing federal Medicaid regulations granted by CMS to allow for new or innovative ways of delivering medical care to residents of a particular state. States are using this mechanism to direct their Medicaid recipients into managed care plans to save money and extend medical care to their uninsured populations.

Medical Loss Ratio (MLR)

A requirement under the ACA that insurance companies spend 80% (for small group and individual market insurers) and 85% (for large group market insurers) of what they receive from enrollee premiums on care provision and quality improvement.

Medical Savings Account

An idea modeled on the concept of individual retirement accounts and often referred to as a medical IRA. Individuals and families would be able to deduct from their taxes each year the amount of money deposited into a designated account to pay for out-of-pocket healthcare expenses.

Medically Necessary

Covered services required to preserve and maintain the health status of a health plan subscriber or eligible person in accordance with generally accepted standards of medical care.

Medicare

A federal government-administered program designed to provide hospital and medical insurance for the elderly and select other groups. Begun in January 1966, CMS now covers more than 55 million people. Medicare Part A covers inpatient hospital services, Part B covers physician-type services, Part C is a commercial insurance option, also known as Medicare Advantage, for the provision of Medicare services, and Part D covers prescription drugs.

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

MACRA was legislation passed by Congress in 2015 that repealed the sustainable growth rate (SGR) payment formula, which linked Medicare payments to prior-year Medicare spending and the gross domestic product. The SGR formula led to yearly threats of severe cuts to Medicare payments for more than a decade. Only the repeated and often last minute interventions by Congress prevented those draconian cuts from actually being enacted. MACRA also set out the initial principles for the Quality Payment Program, which began January 1, 2017.

Medicare-approved Amount

The amount allocated for a service or supply furnished to a Medicare beneficiary. This amount includes Medicare's 80% share of the payment plus the patient's required 20% copay. For example, if the approved amount for a service is $90, Medicare would pay 80% or $72 and the Medicare beneficiary would pay 20% or $18 (assuming that the patient has already met the deductible). PAs, because they are required to accept assignment, cannot charge more than the Medicare-approved amount. Physicians who are participating in Medicare agree to charge no more than the Medicare-approved amount (also known as accepting assignment). Non-participating physicians who are do not have to limit themselves to the Medicare-approved amount. They may balance bill the Medicare beneficiary and charge up to 115% of the approved amount. PAs are reimbursed at 85% of the Medicare-approved amount.

Medicare Administrative Contractor (MAC)

Commercial insurance companies contracted with Medicare to administer Medicare claims in a specific geographic jurisdiction.

Medicare Internet Only Manuals (IOMs)

The Internet Only Manuals (IOMs) are online copies of CMS's official policies. Prior to the adoption of this electronic system, policies were published in the Medicare Carriers Manual in hard copy. Now IOMs are posted on the CMS website.

Medicare Part A

This hospital insurance covers inpatient hospitalization and nursing facility care, home healthcare, and hospice care.

Medicare Part B

This medical insurance covers professional services provided by physicians, PAs, and other authorized practitioners in a range of office and facility settings. It also pays for durable medical equipment.

Medicare Part C (Medicare Advantage)

An option under the Medicare program through which beneficiaries elect to receive their healthcare from HMOs or other managed care entities. Medicare Advantage plans often offer an enhanced benefit package to beneficiaries (such as pharmaceuticals, eyeglasses, and routine physicals) as compared to fee-for-service plans. Medicare pays a fixed, capitated monthly amount to plans to provide healthcare to beneficiaries. As of 2016, 17.6 million, or approximately 31% of Medicare beneficiaries, were enrolled in Part C plans.

Medicare Part D

Medicare Part D is a prescription drug plan for seniors created by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In 2016, nearly 41 million people were receiving assistance with their prescription drug costs through a Part D plan.

Medicare Payment Advisory Commission (MedPAC)

MedPAC is charged with advising Congress on Medicare payment policies and other issues affecting Medicare and the broader healthcare system. MedPAC merges the roles of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, which previously provided Congress with advice and analysis on issues affecting Medicare Parts A and B, respectively.

Medicare Shared Savings Program

As part of the Affordable Care Act, Congress created the Medicare Shared Savings Program to improve quality of care and reduce costs for Medicare fee-for-service beneficiaries, through coordination and cooperation of providers participating in accountable care organizations (ACOs). The Shared Savings Program rewards ACOs that lower costs while meeting standards of quality and assuring that care of patients is their first priority.

Medicare Supplement Policy

Sometimes known as a Medigap policy, this type of privately purchased health insurance policy covers certain Medicare costs that otherwise would have to be paid by beneficiaries. These costs can include the deductible for Medicare Part A (hospitalization) and days as an inpatient in excess of those covered by Medicare. Supplement plans may also pay the 20% of the Medicare Part B fee for which the patient is responsible.

Merit-based Incentive Payment System (MIPS)

MIPS is a Medicare payment methodology that utilizes quality metrics (replacing PQRS), cost (replacing VBM), advancing care information (which replaces meaningful use of electronic health records), and improvement activities concepts to develop a composite performance score for eligible healthcare professionals. The composite performance score will impact whether a healthcare professional will receive a bonus or a penalty on Medicare reimbursements two years later. Medicare's Quality Payment Program, (QPP) which includes MIPS and Advanced Alternative Payment Models (Advanced APMs), began January 1, 2017 with payment bonuses and penalties beginning in January 2019. The MIPS cost component will begin to impact the composite score in year two (2018).

Merit-based Incentive Payment System Alternative Payment Models (MIPS APMs)

APMs that do not meet Advanced APM status and thus must participate in MIPS. However, due to the fact that they are an APM, special rules regarding data submission and scoring apply to them.

Modifier Codes

A coding convention in which a two-digit alpha or numeric suffix is attached to a CPT or HCPCS procedural code on the 1500 billing form to add additional information about the provision of care.

In the past, PAs used various alpha modifier codes when treating patients in the hospital, nursing facility,

rural Health Professional Shortage Area and for first assisting at surgery. As of January 1, 1998, under Medicare, PAs only use the -AS modifier when first assisting at surgery. All of the other PA-specific modifiers have been deleted. PAs continue to use numeric modifiers, as do physicians, to describe certain services they provide to Medicare patients.

N

National Commission on Certification of Physician Assistants (NCCPA)

The national PA regulatory body, which administers the national exams and logs continuing medical education credit.

National Committee for Quality Assurance (NCQA)

An independent accrediting body for MCOs that attempts to improve the quality and service of MCOs by reviewing and analyzing their performance.

National Provider Identifier (NPI)

A federally mandated unique 10-digit identification number that is issued to healthcare professionals and stays with them throughout their career. It is the one identification number used by all public and commercial payers to identify healthcare professionals for reporting claims information and other healthcare information and transactions.

Navigator

An organization or individual trained to provide free-of-charge unbiased assistance to consumers on potential coverage and financial assistance options through the Health Insurance Marketplaces. Navigators also educate local groups about the existence of the marketplaces. Each state has its own set of navigators.

Network Adequacy

The ability of a public or commercial health insurance plan to make available an appropriate number of both primary and specialty care healthcare professionals to ensure that patients have reasonable access to covered health services.

Network Model HMO

An arrangement in which group practices (either single or multispecialty) contract with an HMO to provide specific services at a fixed fee. Each group practice can determine how fees are distributed to individual providers within the group. Typically, providers work out of their own offices and will also see private, traditional, fee-for-service patients in addition to the HMO referral patients. Network model HMOs are usually not eligible to be federally qualified.

O

Open Enrollment

The time span during which individuals in a dual choice health benefits program can select among the various health plans being offered. Open enrollment is also referred to in Section 110.107 of the federal

qualification regulations, as the period in which a federally qualified HMO must make its coverage available without restrictions to individual (nongroup) subscribers who wish to enroll.

Operative Report

The surgical report and prognosis usually dictated and signed by the attending physician after a surgical operation has been performed.

Opt Out

The decision of some healthcare professionals to "opt out" of Medicare and enter into private contracts with patients for reimbursement, as opposed to being a participating provider in the Medicare program. Should a healthcare professional wish to participate in the Medicare program again, he or she must actively request inclusion, which would take effect after the completion of a required two-year opt-out term. However, a healthcare professional may also reverse an opt-out election within the first 90 days of requesting one.

Ordering and Referring Provider

A healthcare professional enrolled in a program who is permitted to order and refer for items and services. The term is frequently used in conjunction with claims to denote which healthcare professional ordered/referred/certified an item or service. This status is distinguished from "rendering provider," which permits a healthcare professional to denote on a claim that they have rendered services to patients. PAs are enrolled at minimum as ordering and referring providers under Medicare, Medicaid (as required by the ACA), and under many commercial plans.

Out-of-Network

Services provided by a PA, physician or hospital that are not part of the managed care plan's practitioner panel. If the health plan offers subscribers the option of receiving care from nonpanel practitioners, the member will normally incur additional financial obligations. If this option is not available, out-of-network services may be covered only with the specific permission of the managed care plan's medical director.

Out-of-Pocket Costs

The amount of money (usually an insured person's deductible and 20% coinsurance) that the third-party payer does not cover. With some HMOs and PPOs, the out-of-pocket costs can be considered the payment required at each visit (e.g., $10 or $20 per visit).

P

Patient-Centered Medical Homes (PCMHs)

Patient-centered medical homes are a type of healthcare delivery model that focuses on team-oriented delivery systems intended to provide comprehensive primary care to patients through proper communication and coordination, primarily in the outpatient setting. Organizations and agencies have varying definitions of PCMHs, but most use provider-neutral language when discussing which professionals may lead the team.

Patient-Centered Outcomes Research Institute (PCORI)

Established by the ACA, this nongovernmental nonprofit seeks to increase the amount of evidence used in decision making by funding comparative effectiveness research. PCORI actively involves patients in the process of designing, developing, reviewing, and using this research.

Patient Relationship Codes

After January 1, 2018, claims submitted for items and services provided by healthcare professionals will include patient relationship codes. These codes will be used to attribute patients and care episodes (in whole or in part) to one or more healthcare professionals. Data collected using these codes will help determine a healthcare professional's "cost" score under MIPS.

Pay for Performance (P4P)

Pay for Performance (P4P) is a set of initiatives to encourage quality of care improvements by rewarding high quality healthcare providers for effective patient care. Healthcare service sites, including physicians' offices, ambulatory care facilities, hospitals, nursing homes, home healthcare agencies, and dialysis facilities, may all participate in these programs. Three Medicare P4P initiatives — the Physician Quality Reporting System (PQRS), value-based modifier (VBM) and Medicare Electronic Health Records (EHRs) Incentive Program — are being absorbed by MIPS.

Physician Compare

A website maintained by CMS that lists healthcare professionals, their contact information and availability, and various indicators of their performance. Its purpose is to assist patients in finding and assessing care options under Medicare. A healthcare professional's QPP performance information will be displayed on Physician Compare to better help beneficiaries in their selection of care options.

Physician Fee Schedule (PFS)

A payment schedule under Medicare used by CMS to reimburse for Part B services. The PFS lists thousands of covered services with corresponding payment rates. These payment rates are determined through an equation that takes into account relative value units, a conversion factor, and geographic practice cost indices. CMS updates the Physician Fee Schedule, allowing public comment, annually.

Physician-focused Payment Models

MACRA established a process through which healthcare professionals may submit plans for new payment models to a Technical Advisory Committee (also known as the PTAC). The PTAC reviews all submissions and determines whether to recommend establishment of the new model to HHS. These newly proposed alternative payment models are known as Physician-focused Payment Models (PFPMs).

Physician Hospital Organization

The alignment of hospital(s) with area physicians to form a type of "community healthcare network." The physicians (with an emphasis on primary care providers) often form an IPA and act as gatekeepers, providing utilization review, case management and quality assurance services. Hospitals typically provide the facility, start-up capital, and organization/management expertise.

Physician Quality Reporting System (PQRS)

PQRS is a Medicare quality reporting program that encourages eligible professionals, including PAs, and group practices to assess the quality of care they provide to their patients by reporting quality measures related to care provided. Successful reporting in 2016 will avoid PQRS negative payment adjustment in 2018. In 2017, quality measures are reported through the quality component of the QPP and PQRS, as PQRS is no longer reported.

Point-of-Service (POS) Option

An option within an employer-sponsored health plan that allows an employee to choose between an HMO/PPO type of plan and a more traditional fee-for-service plan. The employee can choose between the two options each time he or she seeks medical care.

Practicing Physician Advisory Council

A council, appointed by the Department of Health and Human Services (HHS), consisting of 15 practitioners who meet quarterly to advise the secretary of HHS and the administrator of the Centers for Medicare and Medicaid Services about the impact of Medicare policies and regulations on physicians who treat Medicare patients.

Pre-existing Condition

A physical or mental condition that exists prior to the purchase of a health insurance policy or the enrollment of an individual or family member into a healthcare plan. In the past, limits on pre-existing conditions have taken the form of higher premiums, exclusion of payment for certain medical treatment(s) for a set period of time, or total exclusion of coverage. The ACA has since prohibited insurance companies from denying an individual coverage or charging more as a result of pre-existing conditions.

Preferred Provider Organization (PPO)

A group or network of healthcare professionals (or institutions) through which employer-sponsored health benefit plans and health insurance carriers contract to purchase healthcare services for covered beneficiaries from a selected group of participating practitioners. Typically, participating practitioners in PPOs agree to abide by utilization management and other procedures implemented by the PPO and to accept the PPO's reimbursement structure and payment levels, which can be negotiated by an insurer, employer or third-party administrator.

The employer and/or insurance carrier then establish financial incentives in the form of increased benefits for their employees to use the participating preferred hospitals and providers. In contrast to typical HMO coverage, PPO coverage often permits subscribers to use non-PPO providers, although higher levels of coinsurance and deductibles routinely apply to services provided by these nonparticipating providers. PPOs are often formed as a competitive response to HMOs. Some PPOs are now emerging that require providers to share in the financial risk. The incentives for providers and institutions to join the plan can include an increased volume of patients and faster claims payment.

Premium

Often used interchangeably with the term "rate," a premium is the price an insurer charges a beneficiary for a defined set of healthcare benefits.

Premium Insurance Tax Credit (PITC)

An option of financial assistance available to those who purchase certain plans in the Health Insurance Marketplaces under the ACA. Eligible individuals will also have incomes between 100% and 400% of the federal poverty level. These tax credits are available in advance of tax time and go directly to the insurer in order to lower one's monthly premium.

Preventive Services

Services that seek to preempt illness. Such services may include wellness visits, screenings, shots, counseling, and more. The ACA made many routine visits provided by a network provider free of cost to the patient.

Primary Care

The first level of comprehensive healthcare, primary care assumes responsibility for maintaining health (not simply managing illness) with an emphasis on preventive care. Primary care practitioners are generally regarded as consisting of clinicians in family practice, general pediatrics, and general internal medicine.

Prior Authorization

The evaluation of a patient's medical or surgical needs and the approval for care before the procedure is performed; monitoring and controlling a patient's access to medical care.

Privileging

The process by which the governing body of an institution authorizes a healthcare practitioner to provide specific healthcare services. Granting of privileges is based on a person's license, education, training, experience, and competence.

Provider

Technically, under Medicare's definition, a hospital. However, the term is frequently used to describe healthcare practitioners in general.

Provider Directories

Externally facing listings maintained by public and commercial insurers that alert beneficiaries to healthcare professionals within a network. These listings often contain information on the healthcare professionals (such as credentials, location, specialty, whether they are taking new patients, etc.) included to help patients determine the best care option for them.

Provider Profiling

The collection and analysis of medical services, surgical services, and claims data to identify cost, use, and quality-of-care characteristics of healthcare practitioners.

Provider-sponsored Networks (PSNs)

A system of delivering healthcare services in which medical practitioners (e.g., physicians and PAs)

collect premiums, accept risk contracts, and own and control the medical facilities. PSNs contract directly with patients and businesses, thereby eliminating the need for insurance companies, HMOs, and other managed care organizations. Serious issues of financial accountability and solvency, as well as antitrust matters, are of concern to state and federal regulators and legislators.

Q

Qualified Clinical Data Registry (QCDR)

A CMS-approved entity that collects and reports data to CMS on behalf of a healthcare professional or group. QCDRs strive to simplify the reporting process for quality reporting programs. The primary difference between a QCDR and a qualified registry is that the data collected by a qualified registry has historically been exclusive to PQRS measures and are now exclusive to QPP measures.

Qualified Health Plan (QHP)

An insurance plan that is determined qualified to offer coverage on a Health Insurance Marketplace by meeting the ACA's insurance and coverage requirements. To become a QHP, a plan has to be certified by the marketplace in which it is offered.

Qualified Registry

A CMS-approved entity that collects and reports data to CMS on behalf of a healthcare professional or group. QCDRs strive to simplify the reporting process for quality reporting programs. The primary difference between a QCDR and a qualified registry is that the data collected by a qualified registry has historically been exclusive to PQRS measures and are now exclusive to QPP measures.

Quality Assurance (QA)

Activities and programs intended to ensure the quality of care in a defined medical setting. QA programs typically include peer or utilization review procedures to remedy any identified deficiencies in quality. A successful quality assurance program should also have a mechanism for assessing its relative effectiveness.

Quality Payment Program (QPP)

Established by MACRA, the QPP combines various Medicare quality and value programs (the PQRS, value-based modifier, meaningful use) into one. PAs are one of three healthcare professional groups, along with physicians and advanced practice nurses, that qualify as eligible clinicians (ECs) and are required to participate in one of two reporting and reimbursement tracks: the Merit-based Incentive Payment System (MIPS) or the advanced alternative payment models (Advanced APMs).

Quality Report Cards

Periodic ratings of providers (or institutions) given by managed care organizations dealing with quality of care, patient satisfaction and adherence to cost control guidelines.

Quality and Resource Use Report (QRUR)

A report, used by CMS to calculate the value-based modifier, which analyzes quality and cost. QRURs provide comparative analysis, at the TIN level, and influence Part B reimbursement. Solo practitioners

and group practices can also use the data from QRURs for the improvement of care provided to patients.

R

Rate Review

The process by which state insurance departments review increases in prices before such increases are approved. The ACA requires that any large increases in rates are reviewed to ensure they are based on sound evidence. Under the law, insurance companies are also required to provide understandable justifications to their beneficiaries surrounding any such increases.

Relative Value Scale (RVS)

A methodology (not a payment amount or fee schedule) that attempts to show a unit or point rating system of the relationship between the time, severity of illness, and other factors required to perform one professional service as compared to other professional services under usual conditions. Such a scale becomes a fee schedule only when a dollar amount is assigned to each unit or rating point.

Rendering Provider

A medical professional who provides or renders a service to a patient. AAPA advocates for transparency in the claims process so that a rendering PA's name and NPI appear on claim forms to insurers.

Rescission

Occurs when an insurance company retroactively cancels a beneficiary's insurance policy, often due to mistakes on an initial application. The ACA no longer permits insurance companies to do this, unless there's evidence of fraud or intentional misrepresentation.

Resource-based Relative Value Scale (RBRVs)

The relative value scale being used by the Medicare program based on the research conducted at Harvard University by William Hsaio. The purpose of the study was to compare the relative values of physician services. The effect of RBRVS (with partial implementation begun by the Medicare program January 1, 1992) was to increase the value of cognitive, diagnostic (E/M) services and lower the value of specialty and surgical services.

Retrospective Review

Periodic reviews of specific services, tests, or procedures that are conducted in order to identify trends and determine whether healthcare resources are being used appropriately. This concept can be used with individual providers, medical groups, or institutions. When applied to providers, it is often referred to as a provider profile.

Reverse Capitation

A reimbursement method that pays specialists by capitation and primary care physicians by fee-for-service; the reverse of a traditional capitation arrangement.

Risk Pool

An amount of money that is set aside and "at risk" if expenses for treating patients exceed estimates. Commonly, if the pool of money that is at risk is not expended by the end of the year (i.e., the patients required fewer medical services or medical care was provided more efficiently), some or all of the risk pool money is returned to those (providers or others) managing the risk. A risk pool can also refer to a grouping of people to be insured based on their health status, age and other factors.

Rural Health Clinic (RHC)

Also known as a certified rural health clinic. The Rural Health Clinic (RHC) Services Act (Public Law 95-210) was passed in 1977 in an attempt to increase the availability of primary care health services in rural areas. The RHC Act provides Medicare and Medicaid payments for covered services furnished in an RHC by PAs, nurse practitioners (NPs), and certified nurse midwives (CNMs).

The RHC Act requires that a PA, NP, or CNM staff the RHC at least 50% of the time that the clinic is open. Federal RHC regulations also require that the clinic be under the general (not full-time) direction of a physician and that a physician be physically on site at the clinic at least once every two weeks. State laws, which may be more restrictive than federal RHC regulations regarding provisions such as supervision, must be followed.

S

Safety Net Providers

Clinicians, public hospitals, and rural and community health centers that are traditional providers of care to urban or rural underserved populations.

Self-insured Health Plans

Large employers who assume direct responsibility and financial risk for paying (from company funds) their employees' healthcare claims. Businesses usually contract with an outside firm to handle claims payment processing, administrative services, and/or utilization review. Self-insured employer health plans are not required to provide specific benefits or to adhere to individual state insurance mandates, and they do not pay a state insurance tax on their health plan premiums. Self-insured plans are regulated on the federal level by the Employee Retirement Income Security Act of 1974, which is generally less restrictive than individual state regulations.

Shared Visits

Shared visit billing allows a PA and a physician employed by the same entity to share the work of an E/M visit in a hospital setting where both parties have a face-to-face encounter with the patient on the same calendar day. Under this billing concept, the visit is billed using the physician's NPI number for full reimbursement. At this time, shared visit billing does not apply to consults or procedures.

Signature on File

A patient's signature on a form authorizing the release of medical records and/or the assignment of claims benefits. This signed form, normally kept in the patient's file in the physician's office or in the hospital, eliminates the necessity of having the patient sign each and every claim form.

Single-payer System

This concept would guarantee coverage for all citizens with the government paying for all healthcare costs. Funding would be accomplished through a health tax, and the government would likely play a role in setting prices or spending caps (global budgets). Hospitals and medical providers would remain private, but the role of traditional insurance companies would be in question.

Skimming or Cherry Picking

Insurance companies skim when they attempt to market and sell their health policies to individuals and businesses that have the lowest risks and are less likely to need or use healthcare services. Skimming effectively locks out those who fall in the moderate to high medical risk category. Consequently, the premiums charged by the insurers who do provide coverage for increased risk groups are especially high because risk-sharing is reduced.

Smoking and Tobacco-use Cessation Counseling Services

In recognition that tobacco use is a leading cause of preventable death in the United States, Medicare pays for smoking and tobacco-use cessation counseling services for beneficiaries who: use tobacco with or without signs or symptoms of tobacco-related disease; who are competent and alert at the time of counseling services; and whose services are provided by qualified PAs, physicians or other Medicare-recognized practitioners. A smoking cessation counseling session may be either intermediate (3-10 minutes) or intensive (longer than 10 minutes).

Solvency

The financial well-being of an organization (HMO, insurance company, or other entity) that considers both its ability to pay future obligations (claims) and its general cash flow.

Special Enrollment Period

A time outside of the traditional open enrollment period when one is allowed to shop for and purchase insurance as a result of a life event that changes the insurance status. These special enrollment periods last for 60 days in Health Insurance Marketplaces, and 30 days in job settings.

Specialty HMO

An HMO that is organized around a specific medical specialty, such as oncology or cardiac care, and that offers to provide prepaid coverage for those specific medical services.

Specialty Tier Medications

Medications, often without a generic equivalent, placed on the most expensive tier of drugs (Tier IV) by insurers to reduce their financial risk. Patients who require medications in this tier are typically charged a coinsurance instead of a copayment.

Staff Model HMO

A type of HMO in which providers are salaried employees of the HMO, also known as a "vertically integrated HMO." Providers deliver care in facilities owned and operated by the HMO. Generally, patients are required to receive treatment from the providers employed by the HMO. Patients will not be

covered (except in emergency situations) if medical care is obtained outside of the HMO.

State or SpecialTy Advocate for Reimbursement (STAR) Network

A State or SpecialTy Advocate for Reimbursement (STAR) is a PA with an interest in reimbursement, an interest in researching reimbursement policies, and an interest in sharing findings with his or her state or specialty chapter, AAPA, and other PAs. Collectively, STARs form the STAR Network and participate in periodic conference calls with AAPA reimbursement department staff to review current and proposed PA reimbursement policies of public and commercial payers.

Summary of Benefits and Coverage (SBC)

Under the ACA, these easy-to-understand summaries are provided by an insurer for the purpose of comparing costs, coverage features, and services between plans.

Supervision

A term sometimes used to describe the working relationship between PAs and physicians. Because the term fails to adequately describe the autonomous nature of how PAs practice it is less likely to be used and is being replaced by the word collaboration or other terms that more accurately describe how PAs and physicians work together as part of integrated healthcare teams.

Sustainable Growth Rate (SGR)

A physician payment method used by the Centers for Medicare and Medicaid Services until 2015 to control costs of professional services by linking payments to targets based on the GDP. The Medicare Access and CHIP Reauthorization Act of 2015, among other things, eliminated the SGR. From the second half of 2015 through 2019, Medicare fee schedule payment rates will be updated by 0.5% annually. Other provisions of Medicare legislation will impact the fee schedule and could affect the actual payment update.

T

Tax Identification Number (TIN)

A TIN, assigned by the Social Security Administration or by the Internal Revenue Service (IRS), is an identifying number for tax purposes in the United States. An individual's Social Security number is their tax identification number unless they applied for a separate number for their business. A practice's or facility's TIN is commonly placed on a claim form, along with the practice's or facility's NPI, to identify the billing provider. PAs typically bill as a rendering provider.

Telemedicine

The use of communication equipment, such as webcams, to link healthcare professionals with patients in different locations. The goal of telehealth technology is cost efficiency, improved access to care, reduced transportation costs, and improved communication between providers.

Tertiary Care

Subspecialty care usually requiring the facilities of a university-affiliated or teaching hospital that has extensive diagnostic and treatment capabilities.

Third-party Administrator (TPA)

An entity that provides only administrative services for businesses that self-insure their employee health plan. Services typically include utilization review, administration of claims payment, and benefit design. TPAs are not financially at risk for actually paying claims.

Third-party Payer

An entity that acts as a fiscal intermediary between the medical practitioner and the consumer of healthcare. Examples include insurance carriers and the government (through the Medicare and Medicaid programs).

Third-party Reimbursement

A general term applied to healthcare benefit payments. It derives from the fact that under normal market transactions, there are only two parties: the consumer (who is also the payer) and the entity providing the product or service. However, under most health insurance benefit plans, a third party (e.g., the government, an insurance company, or an employer) shares in the payment for medical services provided to covered subscribers.

Tort Reform

A movement to change medical malpractice laws to reduce the need to practice defensive medicine and lower the size of noneconomic malpractice awards.

Total Quality Management (TQM)

The process of examining the operation and outcomes in an organization to identify waste and inefficiency. TQM uses the input and feedback of both employees of the organization and patients to improve operational quality.

TRICARE

TRICARE, formerly known as CHAMPUS, is medical insurance available to all active duty and retired military personnel, their dependents, and survivors of deceased military personnel. Medically necessary services provided by a PA are covered by TRICARE as long as state law is followed and the physician with whom the PA works is an authorized TRICARE provider. PAs are reimbursed at 85% of the Physician Fee Schedule for all services, including first assisting at surgery.

Two-midnight Rule

A CMS rule that states that an inpatient admission will be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that expectation.

U

Unbundling

Separating a service into its individual component parts and billing for each component separately; for example, a total abdominal hysterectomy that is billed as five procedures: laporotomy, evaluation under

anesthesia, hysterectomy, abdominal exploration, and oophorectomy.

Underwriting

The process of selecting, classifying, evaluating, and pricing that is used by an insurer or actuary to determine an individual's or group's insurability.

Uniform Glossary

Under the ACA, insurers must make available an easy-to-understand glossary of terms to help individuals understand complicated health language and acronyms. This glossary is available on www.healthcare.gov as well.

Universal Access

Healthcare that is made available to everyone who can afford the cost (premium). Those who cannot afford the cost are not guaranteed coverage.

Universal Coverage

Healthcare that is guaranteed and made available to everyone, regardless of their ability to pay for coverage.

Upcoding

The inappropriate/illegal practice of designating a higher level or intensity of medical service provided for purposes of realizing greater reimbursement from an insurer or other payer.

Usual, Customary, and Reasonable (UCR)

A method of reimbursing for a provider's services (used most often under a fee-for-service health plan) by paying the full fee requested as long as that fee does not either exceed the amount normally charged for that service by similar providers in the area or is otherwise reasonable based on the medical care required by the patient.

Utilization Management

A systematic method for reviewing and controlling a patient's use of medical services and a healthcare professional's use of medical resources. This process usually involves data collection, utilization review and/or authorization (especially for services such as specialist referrals), and hospitalizations. Typically, managed care organizations establish procedures for reviewing the medical care of subscribers to ensure that care is provided in the most appropriate setting and delivered by the most appropriate provider.

Utilization Review

A system of review conducted by professional personnel to gauge the appropriateness, quality, and need for healthcare services rendered to patients.

V

Value-based Modifier (VBM)

The value-based modifier generates payment differentials to physicians or groups under Medicare's fee schedule based on the quality of care provided compared to the cost of care in a performance period. The payment adjustment is applied at the taxpayer identification number (TIN) level to physicians and, beginning in 2018, to PAs and other Medicare eligible professionals. The cost data is now collected and reported under MIPS as the VBM is no longer reported.

Virtual Groups
Under MIPS, healthcare professionals will have the option to be assessed as a group for MIPS performance categories. Solo and small practices may join "virtual groups" and combine their MIPS reporting activities. The specific details about the implementation of virtual groups is still being formulated by CMS. It is expected that clinicians will be able to join or start virtual groups in 2018.

W

Waiting Period

A specific period of time in which a pre-existing condition or new medical problem will not be covered by a health insurance plan. Also used with disability insurance policies to indicate when, after the onset of a disability, the insurer will begin to pay benefits.

Withhold

The amount or percentage of the provider's monthly capitation payment that is withheld until the end of the year or other predetermined time period to create an incentive for cost-effective care. The withhold amount is "at risk." If the provider (or group of providers) exceeds utilization norms or costs, the withhold amount may not be paid to the provider(s). In theory, withholds serve as a financial incentive for medical providers to deliver more cost-effective care. The withhold can cover all services or be specific to hospital care, laboratory usage or specialty referrals. Sometimes known as a "risk pool."

Workers' Compensation

A state-administered program (sometimes known as industrial insurance) that covers payments for work-related injuries. The state may act as the "insurance entity" or that function may be handled by commercial insurers.