American Academy of PAs

A PRIMER ON PA REIMBURSEMENT

PAs (physician assistants/associates) at every stage of their careers need the latest and most accurate information on reimbursement. With this resource, PAs can quickly familiarize themselves with reimbursement concepts.

Below are sections on different types of payers (Medicare, Medicaid, and commercial). Keep in mind that policies can vary between payers and may even vary from plan to plan and line of business (e.g., commercial, Medicaid managed care, Medicare Advantage, behavioral health, etc.). The section on coding is applicable under all payers.

This information serves as a primer and not an exhaustive list of policies. For more details, please consult the Essential Guide to PA Reimbursement, refer to the American Academy of Physician Associates (AAPA) Reimbursement webpage, or contact AAPA's Reimbursement Team at ReimbursementTeam@aapa.org.

MEDICARE

Eligibility Requirements for a PA to be a Medicare Provider

(Medicare Benefits Policy Manual, Chapter 15, section 190, subsection A)

- Have graduated from an accredited PA program; or
- Have passed the national certification examination administered by NCCPA; and
- Be licensed by the state.

Practical Steps to Becoming a Medicare Provider

- Obtain a National Provider Identifier (NPI).
- Enroll in Medicare through the Provider Enrollment, Chain, and Ownership System (PECOS).

Determinants of a PA's Scope of Practice under Medicare

- Medicare regulations and policies.
- State laws and regulations.
- Hospital bylaws and policies, employer policies, granted privileges, practice agreements.

Required Level of Supervision under Medicare

- Medicare largely defers to state law on how PAs practice with physicians and other members of the healthcare team.
- Personal presence of a physician is generally not required.
- Medicare policies will not override state law or facility policy.

Medicare Reimbursement

- Claims for services are submitted on the paper or electronic 1500 Claim Form.

- Medicare allows PAs to submit claims under their own NPI as the rendering provider and billing provider.
- Most PAs, physicians, and other healthcare practitioners reassign their payment to their employer.
- Services provided by PAs, nurse practitioners, and APRNs are generally reimbursed at 85% of the Physician Fee Schedule.
- There are optional provisions for 100% reimbursement ("incident to" and split (or shared) visits).

"Incident to"

- A Medicare billing provision that allows payment for services performed by PAs at 100% of the Physician Fee Schedule. The claim is submitted identifying a physician as the rendering provider. All specified requirements must be met.
- Requirements:
    - Only applies in the office or clinic (i.e., places of service 11 or 50); it does not apply in a hospital inpatient or outpatient or facility setting (i.e., places of service 19 and 22).
    - Does not apply to commercial payers, Medicare Advantage, or Medicaid, unless specified in policy.
    - The physician must have personally treated the patient and established the diagnosis and treatment plan.
    - The service the PA provides must be incidental to the course of treatment initiated by the physician (i.e., a follow-up visit for an established problem).
    - The physician (or another physician within the practice) must be in the office suite when the PA renders the service.
    - The physician is responsible for the overall care of the patient and must perform services at a frequency that reflects his or her active and ongoing participation in the management of the patient's course of treatment.
- If ALL requirements are met, the encounter can be billed under the physician's NPI for 100%. reimbursement. If ANY are not met, bill under the PA's NPI; reimbursement will be 85%.
- Some Medicare Administrative Contractors (MACs) may have different or additional requirements. Several MACs recommend that clinical documentation support that the physician under whom the service is billed was present and that he or she co-sign the clinical note. PAs and their practices/facilities should follow the specific requirements of their MAC when using "incident to" billing.
- Remember, when not billing Medicare using "incident to":
    - PAs may see new patients as well as established patients with new problems.
    - A physician is not required to see the patient or be on site when care is provided, unless required by state law or facility policy.
    - In these circumstances, claims must be submitted under the PA's NPI number for 85% payment.

Split (or Shared) Visits

- Split (or shared) visits allow a claim to be submitted under a physician for 100% reimbursement in a hospital or facility setting by allowing a PA and physician to "share" the encounter.
- It is only applicable in hospital-owned inpatient and outpatient locations and facilities.
- Requirements:
    - Only for Evaluation and Management (E/M) services (e.g., office or other outpatient services, hospital inpatient and observation services, critical care services, and nursing facility visits) - not procedures.
    - The physician and PA must work for the same group.
    - The physician and PA must see the patient on the same calendar day (not just within 24 hours).

    - They do not need to see the patient at the same time.
    - The physician must provide a “substantive portion” of the service.
    - Either the PA or physician must have a face-to-face encounter with the patient.
    - The physician must sign and date the medical record.
- See AAPA’s Medicare: Split (or Shared) Visit Billing for more information.

Medicare and Surgery

- PAs are authorized to perform minor surgical procedures and first assist for major surgical procedures.
- For first-assist services under Medicare:
    - Use PA's NPI as the rendering provider for the first assist.
    - Bill the surgical code followed by the AS modifier.
    - Reimbursement is 13.6% of primary surgeon's allowable fee.
    - Be aware that special restrictions apply for first assisting in teaching hospitals.
- No payment is made for a PA 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 surgical procedure, unless:
    - A resident is not available.
    - A surgeon has an across-the-board policy of not including residents in the perioperative care of patients.
    - Under exceptional medical circumstances (e.g., life threatening situations such as multiple traumatic injuries).
- PAs should 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 equally to PAs, physicians, and other healthcare practitioners covered for first assisting under Medicare.
- Surgical procedures are bundled services (a “global period") and generally cover the pre-operative H&P and follow-up care.

Medicare and Diagnostic Tests

- Diagnostic tests are assigned one of three levels of supervision: general (least restrictive), direct, or personal (most restrictive).
- PAs can personally perform all diagnostic tests under general supervision according to state law, and PAs may supervise ancillary staff who perform outpatient diagnostic tests requiring general, direct, or personal supervision, as authorized by their scope of practice and state law.

Notable PA Restrictions under Medicare

PAs are NOT authorized to:

- Certify or recertify terminal illness for hospice.
- Certify or order medical nutrition therapy or therapeutic shoes for patients with diabetes.
- Order or supervise cardiac, intensive cardiac, or pulmonary rehabilitation.
- Provide certain required services in acute rehabilitation facilities and skilled nursing facilities that may only be performed by a physician.

MEDICAID

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 and which services PAs are authorized to provide.
- Currently, all 50 states, the District of Columbia, and Puerto Rico 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.

PA Enrollment

- Medicaid enrolls PAs in 48 states and DC, so that a PA's name and NPI can be included on a claim to indicate that they rendered a service.
- All states are required to enroll PAs for the purpose of ordering services and referring patients.

COMMERCIAL PAYERS

Commercial insurers may have their own rules that are similar, the same, or different than the policies of Medicare and Medicaid.

- Some choose not to enroll PAs and instead instruct a PA to bill their services under a physician.
- For those that enroll PAs, some do not discount payment for services provided by PAs.

Payer Policy May Vary

- Due to the variation in commercial payer policies, one must not assume a specific policy.
- The billing and coverage policies must be clearly ascertained by every practice for every payer with whom they contract.

CODING

Current Procedural Terminology (CPT)

- Coding system that classifies diseases and health conditions.
- Over 8,000 five-digit codes - PAs authorized to use virtually all CPT codes.
- Used for billing purposes.

International Classification of Diseases (ICD)

- A medical coding system that classifies disease or diagnosis.
- Used by providers and payers.
- ICD-10 is the version of the coding system currently used in the United States.

Quality Payment Program

The Quality Payment Program (QPP), which went into effect on Jan. 1, 2017, seeks to introduce a comprehensive, value-based health delivery and payment system within the Medicare program by incentivizing certain clinical practice behaviors.

Eligible Clinicians (ECs), which include PAs, follow one of two reporting tracks under the QPP. The first is the Merit-based Incentive Payment System (MIPS). The second track is Advanced Alternative Payment Models (Advanced APMs). The program will either reward those professionals who meet CMS standards for quality, effective electronic health exchange data, practice improvement activities, and cost, or penalize those professionals who fail to do so.

Medicare payments will be affected by the extent to which health professionals meet QPP metrics. Each MIPS-eligible professional's MIPS score and individual category scores will be available on the publicly available Care Compare website. APM participation will also be reported on Care Compare. The financial impact of those bonuses or penalties is on a two-year delay.

For more information on the QPP, visit the CMS QPP website at https://qpp.cms.gov/.

Fraud and Abuse

- *Abuse* includes actions that are improper, inappropriate, outside acceptable standards of professional conduct, or medically unnecessary.
- *Fraud* is an intentional deception or misrepresentation of fact that can result in unauthorized payment.
- Examples of fraud and abuse include but are not limited to:
    - Overcoding, undercoding, and unbundling services that should be billed as a bundle.
    - Providing services that are not medically necessary or appropriate.
    - Falsifying medical records.
    - Offering or accepting kickbacks: solicitation/transfer of something of value to induce/reward behavior.
- Potential fraud and abuse penalties:
    - Payback of reimbursement dollars paid.
    - Civil monetary penalties (up to over $22,000 per incident).
    - Exclusion from Medicare, Medicaid, and other government-related health programs.
    - Imprisonment or other penalties.

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.

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